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Factors affecting the acceptability of assisted suicide.

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Factors Affecting the Acceptability of Assisted Suicide

by

Gayle Vincent

B.A. University of Lethbridge, 1993

A Thesis
Submitted to the Faculty of Graduate Studies
and Research
Through the Department of Psychology
in Partial Fulfilment of the
Requirements for the Degree of
Master of Arts at the
University of Windsor

Windsor, Ontario, Canada
1995

ISBN 0-612-10968-2

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ABSTRACT

The purpose of the current research was to contribute to the debate on assisted suicide by describing: (1) circumstances under which assisted suicide is regarded as an acceptable option, and (2) personal characteristics that mediate acceptance of assisted suicide.

Participants rated scenarios constructed in a factorial design based on the presence (versus absence) of the following factors: terminal illness, physical incapacitation, severe pain, mental incapacitation, and an expressed wish to die. Contrary to the proposed hypotheses, each of these variables alone increased the acceptance of assisted suicide, regardless of whether or not a wish to die had been expressed. Further, in most cases, the effects of these variables were additive.

Participants also completed measures of religious orientation, death anxiety, life ownership orientation, and attitudes toward related issues. Favourable attitudes toward abortion and capital punishment were found to be the best predictors of favourable attitudes toward assisted suicide. Contrary to hypotheses, no other measure significantly predicted acceptability. Policy implications of these findings are discussed.

ACKNOWLEDGEMENTS

This project was completed both quickly and successfully with the help of many people who I would like to take this opportunity to thank. First, to Shelagh Towson, my committee chair, who contributed her exemplary editorial skill as well as her patience through many revisions of this document. She helped greatly to clarify my ideas and to put them in print in a manner that is clear, concise, and much more enjoyable to read. To Glenn Schellenberg, who guided me through more sophisticated statistical procedures than I ever dreamed I could master, and who challenged me, in many ways, to become a better academic. To Michael Kral, who helped greatly to narrow my focus from a more general fascination with death and dying, who listened quietly and patiently to my many ideas, and who not so quietly cheered me on to greater academic heights than I dreamed possible. Finally, to Sharon McMahon, who lent her editorial skill and gentle guidance to make this a better product.

Many people outside those directly involved in this process were also of great help. I would like to thank the members of the Suicide Research Group, those who shared in my morbid curiosity with death and who never tired of hearing me talk about this project in intricate detail. I would also like to thank Janet Keil, Cindy Solylo Pasek, Sonya Vellet, and Tanya Martini, colleagues that I am also proud to call friends and who, from near or far, helped me maintain my link with sanity, an often difficult task during this project. These women share the glory, but they also shared the pain during the birth of this document. I thank them for their unconditional support, and also thank them for participating with me in making Bell Canada a much wealthier corporation.

I must also give thanks to my family -- my mother Marjory Vincent and brother Dan, and my grandparents, Margaret and Charlie Jones, for their love and support through my years as a graduate student. I would particularly like to thank my grandfather, who shared his love of reading and of knowledge with me at a very early age, a gift for which I am more thankful with each passing day. Finally, I must thank my longterm partner, Dion Poirier, who gave me the support and courage to endure, and who did his best to remain patient while I took the time to fulfill my dream.

This thesis is dedicated to you.

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CHAPTER 1

INTRODUCTION

Background

Sue Rodriguez was a Canadian woman who was diagnosed in 1991 with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease. ALS is a disease that slowly causes complete physical paralysis from destruction of spinal cord and brain stem cells, leaving mental functioning intact. ALS eventually results in death, caused by suffocation when control of the lungs and diaphragm is lost (Wood, 1994). Rather than die this way, Rodriguez wanted the option of dying with the help of a physician on the date of her choice.

Sue Rodriguez was denied such assistance by the courts. Under current Canadian law, it is an offence to counsel or to aid in the suicide of another individual, although committing suicide oneself is not a criminal offence (Smith, Alter, & Harder, 1993). Arguing her case before the Supreme Court of Canada, Rodriguez contended that since she was incapable of committing suicide alone, the denial of a physician-assisted suicide was also a denial of her right to "life, liberty and security of the person," as ensured by the Canadian Charter of Rights and Freedoms (Smith, 1993). She further argued that such a denial constituted cruel and unusual treatment because it would either force her to endure prolonged suffering or require her to end her life before she wished (i.e., while she was still capable of committing suicide unassisted). She argued that the law discriminates against disabled people because it deprives them of the right to choose suicide (Smith, 1993).

The Supreme Court of Canada, in a 5-4 decision, rejected Sue Rodriguez's argument on the grounds that the state "has a fundamental interest in protecting human life; [the current law] is designed to protect the vulnerable who, in a moment of weakness, might be persuaded to commit suicide" (Smith, 1993, p.3). Nevertheless, the minority, concluded that

> it would be contrary to the principles of fundamental justice to deny Sue Rodriguez the choice available to those who are physically able, merely because of a fear that others might suffer abuse . . . [the current law] creates an inequality in that physically disabled persons unable to commit suicide without assistance are prevented from choosing that option without breaking the law; those who are capable of ending their lives unassisted, however, may commit suicide with impunity (Smith et al., 1993, p.6)

Although Sue Rodriguez died, the issue of assisted suicide that she brought to the attention of Canadians did not. Ogden (1994) has estimated that assisted suicide may currently account for as many as 20% of the deaths of the Canadian population with AIDS. Further, the split decision of the court on the Rodriguez case strongly suggests that the debate will continue.

This issue is likely to be better dealt with in Parliament than in the courts (Winsor & Cernetig, 1994); consequently, both legislators and lobbyists will need to know the attitudes of the population at large. What proportion of the population accepts the idea of assisted suicide and under what conditions? Moreover, what characteristics discriminate between those most willing to accept assisted suicide and those most opposed to it? The purpose of the current research was to explore these issues. As a first step in this process, it is helpful to "frame" the discussion in terms of the definition of assisted suicide.

Definition of Assisted Suicide

The term "assisted suicide" has yet to be defined adequately, either legally (Dukelow & Nuse, 1991) or in published research. Nevertheless, examination of various definitions of assisted suicide and related terms can help to determine some characteristics common to most instances.

It is helpful to first delineate the commonalities and differences between various forms of death. Homicide, euthanasia, assisted suicide, and suicide exist on a continuum of "volition" or "personal control." At one end of this continuum, homicide is the taking of someone's life against that person's will. Suicide, at the other extreme, is the taking of one's own life voluntarily. Euthanasia and assisted suicide occupy overlapping midpoints on this continuum.

Euthanasia has been defined as "the act of inducing a gentle and easy death" (Simpson & Weiner, 1989, p.444) or, more specifically, as

> the act of putting to death painlessly or allowing to die, as by withholding extreme medical measures, a person or animal suffering from an incurable, especially a painful disease or condition; a painless death (Stein & Urdang, 1987, p. 670).

Euthanasia is often discussed in terms of two dimensions – as either passive or active, voluntary or involuntary. Passive euthanasia refers to an intentional act to avoid the prolongation of life, for example, removing a life-support system. By contrast, active euthanasia is an act intended to cause death, such as by the administration of a lethal injection. Voluntary euthanasia refers to the termination of the life of a competent individual who has specifically requested that their life be ended, whereas involuntary euthanasia refers to the termination of the life of an individual who has not requested death, the presumption in the latter case being that this individual, if able, would communicate such a wish (Ho & Penney, 1991; Smith et al., 1993; Wade & Anglin,

1987).

As with homicide, euthanasia involves one person's taking someone else's life. The factor of intent differentiates euthanasia, in any of its various forms, from homicide. Whereas homicide is considered an act of malice, often arising out of anger, involuntary euthanasia is considered an act of mercy, stemming from a sense of caring or from a wish to put another individual out of their suffering or misery.

The terms voluntary euthanasia and assisted suicide fall more closely on the suicide end of the continuum because they assume a common definitional characteristic not common to homicide: an expressed wish to die on the part of the "target" -- the person who will die. Assisted suicide and voluntary euthanasia are, however, distinct from suicide in terms of ability to carry out the act. Assisted suicide and voluntary euthanasia are, therefore, functionally equivalent. Its alignment to suicide generally, however, has made assisted suicide the more commonly used term today. To clarify the meaning of assisted suicide, then, the following definition will be used:

> Assisted suicide involves the direct, explicit and voluntary request by an individual for aid in successfully terminating their life.

Situational Determinants of Acceptability

Early research (e.g., Johnson, Fitch, Alston & McIntosh, 1980; Kearl & Harris, 1981; Klopfer & Price, 1978; Steininger & Colsher, 1979) found that attitudes toward assisted suicide/euthanasia in general were related to various factors. For example, those who rated themselves as more conservative or more religious were more likely to find euthanasia unacceptable (Adams, Bueche, & Schvaneveldt, 1978; Finlay, 1985; Johnson et al., 1980; Jorgenson & Neubecker, 1981; Steininger & Colsher, 1979).

Those who found abortion or suicide acceptable also accepted assisted suicide (Finlay, 1985; Ho & Penney, 1991; Jorgensen & Neubecker, 1981). Finally, younger people were found to be more accepting of assisted suicide than were older people (Johnson et al., 1980).

Participants in most of these studies were asked to respond to one global statement (or question) regarding whether or not assisted suicide or euthanasia was acceptable. For instance, in Klopfer and Price (1978), participants responded to the following question:

> If a person is incurably ill and suffering terrible pain, and he has money to stay alive a little while longer, should he be allowed to decide that his doctor should put him out of his misery? Remember that only he and maybe his relatives alone would make the decision -- the doctor wouldn't interfere.

In other research (Kearl & Harris, 1981; Jorgenson & Neubecker, 1981), participants have responded to the following:

> When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request?

These particular questions include a combination of some or all of the following situational factors: (a) terminal illness; (b) legal sanction; (c) doctor sanction; (d) physical pain; (e) financial hardship; and
(f) patient and family request for termination of life. The co-occurrence of more than one of these factors makes it impossible to speculate on the unique contribution of each factor or on possible interactions between factors.

Wade and Anglin (1987) attempted to address this problem by developing a list of 17 hypothetical situations, which were designed as a function of each of the

following factors: whether or not there was an expressed wish to die, likelihood of recovery (either 50 percent or 10 percent), level of pain (either extreme or moderate), and level of physical functioning (confined to bed, inability to perform self-care tasks, loss of bodily functions, deteriorating muscles, or confined to wheelchair), level of mental functioning (either diagnosis of "brain dead" or mental incapacitation), sanction (either medical or legal), amount of psychological stress experienced by the family, and financial hardship experienced by the family. Participants were asked to respond by rating each situation on a 7-point Likert scale, from "strongly against termination" to "strongly for termination", first if they themselves were a candidate for euthanasia, then if the candidate was their mother, and finally if it was their father. When rating themselves as candidates, participants were accepting of euthanasia/assisted suicide only if diagnosed as "brain dead" or mentally incapacitated. Euthanasia was an acceptable option when either of the respondent's parents was a candidate, but only if the parent was diagnosed as 'brain dead' or had explicitly expressed a wish to die.

The finding that euthanasia/assisted suicide is acceptable when a wish to die has been expressed suggests that the responses of participants in the Wade and Anglin (1987) study might have been different if the other reasons for terminating life (such as pain or terminal illness) had been accompanied by an expressed wish to die. Their participants judged each factor alone; in real life, it is unlikely that a wish to die would be expressed without some accompanying explanation. Hence, the acceptability of assisted suicide would likely vary on the basis of whether or not a wish to die has been expressed. Other variables could moderate this effect. For example, assisted suicide might be viewed as more acceptable for a person who has expressed a wish to die if that person is also in great physical pain. The purpose of the current study was to test

the role that different variables play in influencing the acceptability of assisted suicide. Of particular interest was the influence of variables other than volition and how these might interact with volition.

On the basis of previous research, several situational factors appear to be important in delineating situations in which assisted suicide is acceptable from those in which it is not. A discussion of these factors follows.

Target Volition

An expressed wish to die, or a direct request by the individual for others to help them end their life, is central to the definition of assisted suicide discussed earlier. It is not surprising, therefore, that parents' expressed wish to die predicted endorsement of euthanasia in Wade and Anglin's (1987) study.

Chance of Recovery

Ogden (1994) reported that the incidence of assisted suicide is greatest among the terminally ill, such as people in the final stages of AIDS. Wade and Anglin (1987), however, did not ask their participants to rate the acceptability of euthanasia when faced with a terminal illness; rather, the question was framed in terms of chance of recovery, either 50 or 10 percent. When framed this way, participants did not rate euthanasia/assisted suicide as an acceptable option in either circumstance.

Other authors have more directly tested attitudes related to terminal illness (Deluty, 1988; 1989; Range & Martin, 1990), reporting that suicide was viewed as more acceptable for individuals with a terminal illness than for those with either chronic physical or psychological pain. The perception that the target's illness is terminal may be a primary factor in people's judgments concerning the acceptability of assisted suicide.

Physical Incapacitation

The term physical incapacitation, as used in this study, refers to a limitation of physical functioning whereby an individual cannot perform acts of self-care (e.g., feeding, dressing, or personal hygiene) and is confined to a wheelchair or bed. For some, this condition reduces human dignity, resulting in so low a quality of life that death may be preferable.

A recent case in Canada serves as a good example both of the wish to die because of reduced quality of life (rather than pain or the terminal nature of the illness) and of the legal confusion surrounding assisted suicide. A young woman with Guillian-Barre syndrome was mentally competent but paralyzed from the neck down. She won the right to have her respirator removed, and died shortly afterwards (Fennell, 1992). The distinction between her case and those referred to previously would seem to be the passive nature of the assistance required to bring about her death.

Wade and Anglin (1987) asked their participants to indicate which of several physically incapacitating conditions they would accept for either themselves or a parent as a justification for assisted suicide (i.e., confined to bed or a wheelchair, inability to perform self-care tasks, loss of bodily functions, or deteriorating muscles). These authors found that no situation was viewed by participants as an adequate justification for the decision to terminate life. These conditions are not, however, mutually exclusive. For example, a person who is confined to bed may not be able to perform self-care tasks. If the participants had been presented with scenarios in which they or their parents were suffering from several of these incapacitating conditions at once, they might have indicated greater acceptance of assisted suicide.

Mental Incapacitation

Wade and Anglin (1987) reported that a diagnosis of mental incapacitation led participants to endorse euthanasia for themselves but not for their parents. This finding suggests that different decisional criteria may be used in deciding the fate of oneself or another. Participants may presume that they would not wish to live if mentally incapacitated; they may not believe, however, that they could (or should) make life-and-death decisions for another person whose wishes may or may not be known, even if mental incapacitation is a factor. It is interesting to note that, in practice, individuals whose level of mental functioning is impaired are being assisted in ending their lives, as in the case of Cec Brush, a man with Alzheimer's Disease (a disease causing deterioration of the brain and concomitant loss of mental function), whose wife stabbed him to death at his request (Steele, 1995). Mrs. Brush was subsequently acquitted of murder charges.

Level of Pain

Chronic, debilitating, and/or terminal illnesses often involve pain. According to Dorpat, Anderson and Ripley (1968), chronic pain is a condition that often precedes a suicide attempt. Individuals who are experiencing severe, chronic, and unmanageable pain or individuals for whom drug therapy reduces quality of life by causing a perpetual stupor may be viewed as legitimate candidates for assisted suicide (Ogden, 1994; Wade & Anglin, 1987).

Personal Determinants of Acceptability

Religious Orientation

Degree of religiosity predicts attitudes toward assisted suicide. For example, there is a negative association between pro-euthanasia attitudes and the frequency of

attendance at religious services. Moreover, those who define their faith as "strong" are much more likely to reject the notion of active euthanasia (Adams et al., 1978; Johnson, et al., 1980; Jorgenson & Neubecker, 1981). Catholics have been found to be more opposed to euthanasia than Protestants (Ostheimer & Moore, 1981; Singh, 1979). Wade and Anglin (1987) found that those who report a high degree of religiosity have negative attitudes toward euthanasia.

Much of this research has been criticized, however, on the basis that the measures used (whether single item or a complete scale), are too general and may be interpreted differently by different respondents, or that demand characteristics may affect participants' responses. Batson and Gray (1981) concluded that such self-report measures are inadequate tools to assess religiosity. They proposed that rather than having a strong or a weak commitment to religion, a person can have a means, an end, or a quest orientation. A means or extrinsic orientation to religion reflects the use of religion as a means to other ends, for example, social status or security. An end or intrinsic orientation reflects a sincere, committed approach to religion as an intrinsically-valued end in itself. It also represents a view of religion as providing a set of absolute rules to live by; people with an intrinsic orientation accept religious doctrine without question. In contrast, a quest orientation reflects an open-ended search in which religion is seen as a process of questioning, doubting, and re-examining ultimate values and beliefs (Batson & Gray, 1981).

Darley and Batson (1973) examined the association between religious orientation and helping behaviour. Those with an intrinsic orientation were persistent in helping, often refusing to leave someone they believed needed help (a confederate) even after he had stated that he wished to be left alone. In this case, the helping

response was not modified by the stated wish of the confederate. By contrast, those with a quest orientation tended to respond more to the actual expressed need of the confederate rather than to their own need to help.

In this and subsequent research (Batson & Gray, 1981, Batson, et al., 1989), both extrinsic and intrinsic orientations were associated with seeking social and self-rewards as the goal of helping someone in need; whether or not that the person in need would benefit from such help was essentially irrelevant. A quest orientation, on the other hand, was positively associated with responding to need as expressed by the individual in need of help rather than responding to the participant's own need to help.

Consistent with past research (Batson & Gray, 1981), it was proposed in the present study that those with a strong means (extrinsic) or end (intrinsic) religious orientation would respond to their own need to help rather than to the victim's expressed wish to die. Whether their need is to be faithful to the church, to receive approval from their peers, or to reap self-rewards, such individuals were expected to reject assisted suicide for two reasons: (1) assisted suicide has been deemed "wrong" by most mainstream churches, and (2) it would prevent their further helping of the victim and thus would limit their reward. In short, it was proposed that for individuals with a means or end orientation, assisted suicide would be viewed as unacceptable, regardless of the wishes of the victim. By contrast, those who exhibited a quest orientation to religion would be more likely to respond to the expressed needs of the target, viewing assisted suicide as unacceptable if it has not been requested by the target, but as acceptable if a request for an early death has been made.

Death Anxiety

According to Lester (1993), death anxiety refers to an anxiety about both death and dying and related issues for both oneself and others. It is reasonable to suppose that level of death anxiety would affect attitudes toward assisted suicide, with those experiencing higher death anxiety having more negative attitudes. Nevertheless, Slezak (1982) failed to find an association between death anxiety and attitudes toward voluntary, passive euthanasia among college students, although Devins (1979) reported a significant negative correlation between the two factors for elderly but not for younger participants. Slezak (1982) suggested that death and the issues surrounding it may be more salient for older than for younger people.

Previous studies measured these types of attitudes using scales such as the Templer Death Anxiety Scale (e.g., Slezak, 1982), the Euthanasia Ideology and Behavioral Scales (e.g., Adams et al., 1978), fear of death tested at three levels of awareness (Feifel & Schag, 1980), the Revised Death Anxiety Scale (Thorson & Powell, 1992), and two versions of the Collett-Lester Fear of Death and Dying Scale (Lester, 1990), scales designed primarily to measure the participant's fear of their own death. Slezak (1982) suggested that, for college students, one's own death may be too abstract a concept to elicit a significant response. Consequently, such scales may be inappropriate. Scales that measure the participant's fear of the death and dying of others would be more appropriate, because most participants would have experienced (or at least considered) the death of a grandparent or other loved one.

Life Ownership Orientation

Life ownership orientation, specifically the belief that life belongs to the individual rather than to God or to the state, has been found to be positively associated

with positive attitudes toward assisted suicide. Conversely, the belief that life belongs to God was negatively associated with attitudes toward assisted suicide (Ross & Kaplan, 1993). Further, life ownership was found to be a better predictor of attitudes toward assisted suicide than tests of either religiosity or political liberalism-conservatism (Ross & Kaplan, 1993).

Gender of Respondent

Gender differences in attitudes toward assisted suicide/euthanasia remain unclear and require further study. For instance, Wade and Anglin (1987) and Ho and Penney (1991) found no sex differences in attitudes toward euthanasia (passive or active). On the other hand, Johnson et al. (1980) and Jorgenson and Neubecker (1981) found that men were more favourable toward euthanasia than women. Although Finlay (1985) reported a similar effect, it disappeared when religious and morality variables were controlled.

Attitudes Toward Related Issues

Information concerning related issues, such as attitudes toward abortion and capital punishment have been found previously to be associated with attitudes toward assisted suicide (Ross & Kaplan, 1993).

In addition to indicating their attitudes on these issues, participants were asked to indicate their attitudes toward the legalization of assisted suicide in Canada and who they believe should be responsible for the decision to terminate life in these instances.

Hypotheses:

On the basis of the above, the following hypotheses were advanced:

1. Participants' endorsement of assisted suicide will be significantly greater for individuals who have expressed a wish to die than for individuals who have not expressed such a wish.
2. Participants' endorsement of assisted suicide for individuals who have expressed a wish to die will be significantly greater when this wish is coupled with one or more of the following factors: the presence of a terminal illness, severe pain, physical incapacitation, and mental incapacitation.
3. Participants' endorsement of assisted suicide for individuals who have not expressed a wish to die will not be significantly greater when this wish is coupled with one of more of the following: presence of a terminal illness, severe pain, physical incapacitation, and mental incapacitation.
4. Acceptance of assisted suicide will be negatively correlated with a means or end orientation to religion, death anxiety, and the belief that life belongs to God.
5. Acceptance of assisted suicide if a wish to die has been expressed will be positively correlated with a quest orientation to religion.

CHAPTER 2

METHOD

Subjects

The participants included 111 introductory psychology students, 72 (65%) female and 39 (35%) male, who ranged in age from 18 to 54, with a mean age of 21.2 years. The majority of respondents (91%) were single. Participants identified themselves as members of the following ethnic groups: 75% Caucasian, 10% Middle Eastern, 5% Asian, 5% Eastern European, 4% African Canadian, 1% Native, and 2% unidentified. In terms of religious affiliation, 44% of the participants were Catholic, 28% Protestant, 12% Atheist/Agnostic, 3% Muslim, 3% Jewish, 1% Buddhist, and 1% Sikh. Forty-four percent of the participants described themselves as very religious, 24% attending religious functions at least once a week. In terms of previous exposure to information concerning assisted suicide, 94% of the participants had been exposed to this issue prior to participation in this study, either through the media or through coursework.

Procedure

Individuals recruited from introductory psychology classes completed the study measures in a university classroom in small groups of 5 to 12. Upon arrival, participants read and signed an informed consent letter (Appendix A). Participants then received a survey package, the first part of which included thirty-two randomly ordered vignettes (different order for each participant) (Appendix B).

After completing the vignettes, participants were asked to continue with subsequent sections of the survey package, including a request for demographic information (Appendix C), and scales measuring death anxiety, religious orientation, and life ownership orientation (Appendix D). Participants were asked their views on abortion, capital punishment, and the legalization of assisted suicide, and asked who should be responsible for deciding when an assisted suicide is an appropriate option (Appendix D). Finally, participants were given the opportunity to make any comments concerning the survey itself or concerning issues surrounding assisted suicide, to be analyzed at a later date. When participants had completed all measures, they were given a debriefing letter (Appendix E), and given the opportunity to ask any questions, and were thanked for their participation.

Measures

Situational Determinants of Acceptability

In each vignette, a woman was described with one of the following conditions: multiple sclerosis, lupus, lung cancer, or a brain tumor. Each vignette also contained all situational determinants, in the following order: chance of recovery (terminal or non-terminal illness); physical incapacitation (able or not able to function physically); level of pain (severe pain or no pain); mental incapacitation (able or not able to function mentally); and volition (had or had never told the doctor she wants to die). One example follows, in which the woman was terminally ill, physically incapacitated but mentally alert and had not expressed a wish to die.

> Naomi hadn't been feeling quite right, so she went for a physical exam. During the exam, she told her doctor that she sometimes felt lightheaded and had double vision, and that she sometimes had trouble carrying things because the muscles in her arms felt so sore and weak. Naomi was diagnosed with multiple sclerosis, a potentially fatal disease. Naomi's disease had progressed very quickly; her doctor told her that she could not expect to live more than a few months. Her disease has made Naomi very weak; she has had to quit work at a job that was very physically demanding, and now is confined to bed. She will probably be confined to a bed or a wheelchair for the rest of her life. Further, because she can no longer control her bladder, she must wear a diaper. Medication has helped, and Naomi is not in any pain as a result of the disease. Naomi is still mentally alert, and is still capable of making conversation with her family and old coworkers. Now, imagine that you are Naomi's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

After reading each vignette, participants were asked to rate on a 7-point Likert scale (1 = completely acceptable, 7 = completely unacceptable) how acceptable they thought it was for them to help Naomi to die (Appendix B).

Personal Determinants of Acceptability

Demographic Information

Participants were asked to report their gender, age, marital status and ethnic background.

Religious Orientation

Means (extrinsic) and end (intrinsic) religious orientation was assessed with the Extrinsic-Intrinsic Religious Orientation Scale (Allport & Ross, 1967) (Appendix D). Allport and Ross (1967) reported item-to-subscale correlations ranging from .18 to .58. Cronbach's alpha was not available for this scale.

Quest religious orientation was measured with the Quest Scale (Batson, 1976; Batson & Schoenrade, 1991a) (Appendix D), a revised, 12-item scale based on an original 6-item version (Batson, 1976; Batson & Schoenrade, 1991a; 1991b). Batson

(1976) reported low correlations between the Quest Scale and the Extrinsic (from .00 to .25) and Intrinsic Scale (from -.10 to .10), respectively. Internal consistency for the 12-item Quest Scale was high (Cronbach's alpha of .75 to .82). The revised scale was highly correlated with the original scale (.85 to .90) (Batson, 1976).

Participants were also asked their religious affiliation, how often they attended church services/functions, and to rate how religious they are on a five-point Likert scale (1 = very religious, 5 = not at all religious) (Appendix D).

Death Anxiety

Death anxiety was measured using the four subscales of the Collett-Lester Fear of Death Scale (Lester, 1990). Participants responded to items on the basis of how anxious they were made by that item. Responses ranged on a 5-point Likert scale (1 = not anxious, 5 = very anxious).

Each subscale (Your Own Death, Your Own Dying, Death of Others, and Dying of Others) consists of eight items. Lester (1990) reported test-retest reliabilities for each subscale as follows: .85 for death of self, .79 for dying of self, .86 for death of others, and .83 for dying of others. Cronbach's alpha for each subscale follow: .91 for death of self, .89 for dying of self, .72 for death of others, and .87 for dying of others. Studies testing the concurrent validity of this scale with other, more general fear of death scales have yielded correlations ranging from .40 to .55 (Lester, 1990). These moderate correlations can be accounted for by the greater specificity of this scale compared to others with which it was compared.

Life Ownership Orientation

Life Ownership Orientation was measured using the three subscales of the 21-item Life Ownership Orientation survey (Ross & Kaplan, 1993), which include Life Ownership to God (LOOQ-G), Life Ownership to the Individual (LOOQ-I), and Life Ownership to the State (LOOQ-S). Each subscale consists of seven items. Participants responded to items on the basis of their agreement/disagreement with the item, ranging from "strongly agree"(1) to "strongly disagree"(7).

The LOOQ-G subscale has a reliability alpha of .88, the LOOQ-I had a reliability alpha of .67, and the LOOQ-S had a reliability alpha of .50 (Ross & Kaplan, 1993).

Attitudes Toward Related Issues

Information concerning attitudes toward abortion and capital punishment was collected via participant responses to the following statements: "It is acceptable for a woman to terminate her pregnancy by having an abortion," and "Capital punishment should be legalized in Canada." Participants responded to these items on a scale from "strongly agree" (1) to "strongly disagree" (7) (Appendix D).

Attitudes toward the legalization of assisted suicide and who should be made responsible for the decision to terminate life were examined using the following two items: "Doctor-assisted suicide should be legalized in Canada," and "Who should decide whether a person should be allowed an assisted suicide?" Responses to the former item was collected on a 7-point Likert scale (1 = strongly agree, 7 = strongly disagree). For the latter item, respondents chose as many options as they felt applied (i.e., individual, doctor, family, government, court, and other) (Appendix D).

CHAPTER 3

Results

Situational Determinants of Acceptability

In order to determine the conditions under which assisted suicide would be considered an acceptable option, logistic regression analyses were conducted to model acceptability as a function of the gender of the research participant and the five factors used to construct the scenarios (presence versus absence of expressed wish to die, terminal illness, physical incapacitation, pain, and mental incapacitation). Hence, the experimental unit in this set of analyses is the assisted suicide target rather than the study participants. Responses to each vignette on the 7-point Likert scale regarding acceptability of assisted suicide were recoded as a dichotomous variable. The decision was made to recode responses of 1 to 4 as accepting assisted suicide; responses of 5 to 7 were scored as rejecting assisted suicide. A median split supported this decision. Using this criterion, overall acceptance was relatively high; 58 of the 111 respondents (52.3%) reported that assisted suicide is acceptable at least once.

Other statistical methods were considered and rejected in favour of logistic regression. Multiple regression analysis of acceptability ratings as a continuous variable was rejected because this method would average responses across subjects. Because there was much disagreement across participants (participant intercorrelations were low), this approach was inappropriate. Repeated measures analysis of variance was also rejected because it assumes homogeneity of covariance, and tests of covariance revealed a large violation of this assumption.

Tests of statistical significance in logistic regression are conducted by comparing different 'models' of the proportion of subjects who judged assisted suicide to be acceptable. A model consisting solely of an additive combination of the main effects (gender of research participant and the five factors from the vignettes) was revealed to significantly reduce the deviance from the independence model ($\chi^2_6 = 557.9$, $p<.0001$), which is based solely on the mean number of participants finding assisted suicide acceptable across all scenarios.

Each variable was removed singularly from the model to test whether it made a statistically significant contribution to the fit of the model. Each predictor made a significant contribution (Figure 1). Assisted suicide was more acceptable when the research participant was male rather than female, when the target had expressed a wish to die, was physically incapacitated, was mentally incapacitated, was in pain, or was terminally ill.

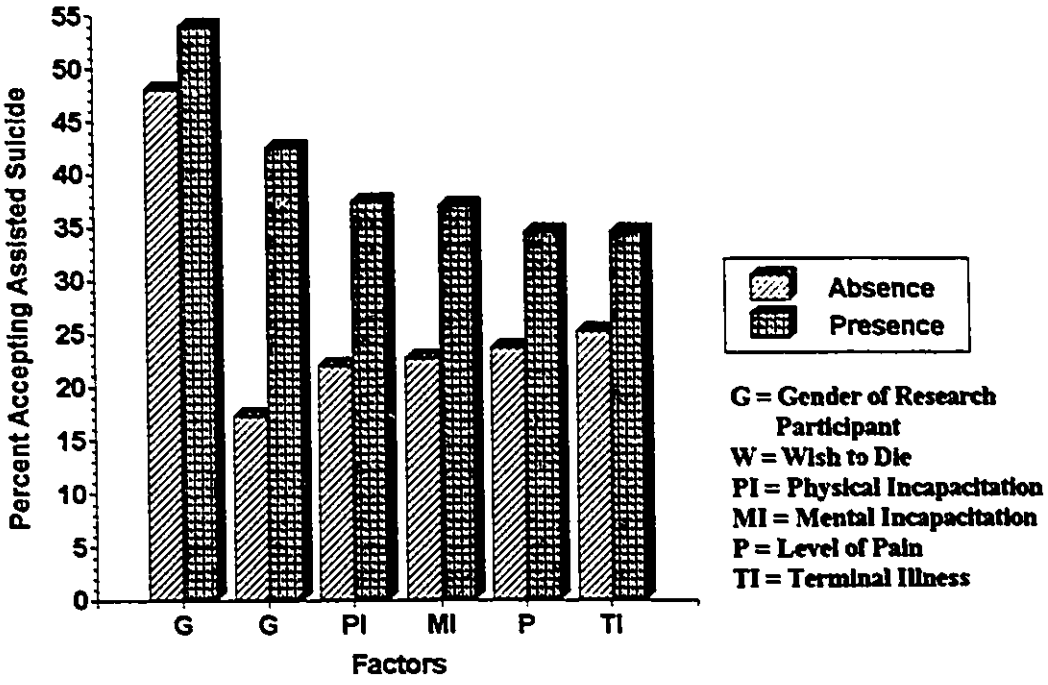

Figure 1. Percentage of participants accepting assisted suicide as a function of absence or presence of each factor.

Note: For the variable Gender, absence refers to female and presence refers to male.

The odds ratio for each predictor variable was significantly greater than 1 (Table 1). An odds ratio is the proportion of respondents finding the assisted suicide acceptable divided by the proportion who find it unacceptable. For example, the odds of finding an assisted suicide to be acceptable were 3.09 times greater when the target had expressed a wish to die (versus no wish).

Table 1

Logistic Regression For Acceptability of Assisted Suicide According to Target Circumstance and Participant Gender -- Main Effects Model

Circumstance	Change in Deviance (G^2)	Odds Ratio	95% Confidence Interval for Odds Ratio	
			Upper Limit	Lower Limit
Wish to Die	215.10*	3.09	2.94	3.24
Participant Gender	135.00*	2.50	2.19	2.81
Physical Incapacitation	87.69*	2.06	1.91	2.21
Mental Incapacitation	70.33*	1.91	1.76	2.06
Pain	57.07*	1.79	1.64	1.94
Terminal Illness	29.41*	1.52	1.36	1.67

$n = 64$.
* $p < .0001$

The main effects model left a significant amount of deviance or variance unexplained ($\chi^2_{57} = 126.67$, $p<.0001$). Accordingly, a more complete explanation of response patterns was derived by adding two-way interaction terms to the model. The final model contained six two-way interactions in addition to the six main effects and significantly reduced the deviance left unexplained by the main effects model ($\chi^2_7 = 654.4$, $p<.0001$). Moreover, the final model did not signifanctly differ from the saturated, or perfect fit model ($\chi^2_{51}=66.83$, $p>.01$) (Table 2).

Table 2

Final Logistic Regression Model For Situational Determinants of Acceptability of Assisted Suicide

$\log((p)/(1-p)) = -1.964 + 1.127\,(W) - .9168\,(G) + .7217\,(PH) + .6464\,(M) + .5824\,(P) + .4182\,(T) + 1.214\,(W * G) - .6966\,(T * PH) + .4221\,(T * M) - .4185\,(PH * W) + .3337\,(P * M) + .3135\,(M * W)$

G^2 (deviance or unexplained variance)= $\chi^2_{51} = 66.83$, $p > .01$, n.s.

p = proportion of people accepting assisted suicide
Gender = Gender of Research Participant
PI = Physical Functioning, incapacitated or capable
P = Level of Pain, severe or nonexistent
W = Wish to Die, expressed or unexpressed
TI = Nature of the Illness, terminal or nonterminal
MI = Mental Functioning, incapacitated or capable

Significant interactions were found between the following pairs of variables, listed in descending order of the magnitude of their contribution to the model: (1) wish to die and gender; (2) terminal illness and physical incapacitation; (3) terminal illness and mental incapacitation; (4) physical incapacitation and wish to die; (5) pain and mental incapacitation; and (6) mental incapacitation and wish to die (Table 3).

Table 3

Significant Interactions in Final Model

Interaction	Change in Deviance (G^2)	Odds Ratio	95% Confidence Interval for Odds Ratio	
			Upper Limit	Lower Limit
Wish to Die X Gender	55.47***	3.36	2.75	3.97
Terminal Illness X Physical Incapacitation	19.79***	2.01	2.41	1.61
Terminal Illness X Mental Incapacitation	7.19**	1.53	.93	2.13
Physical Incapacitation X Wish to Die	7.00**	1.52	.89	2.15
Pain X Mental Incapacitation	4.16*	1.40	.80	2.00
Mental Incapacitation X Wish to Die	3.79*	1.36	.74	2.25

n=64.
*** $p < .0001$
** $p < .001$
* $p < .01$

An interpretation of each interaction follows:

The interaction between wish to die and gender (Figure 2) reflected the fact that men were more accepting of assisted suicide than women when a wish to die had not been expressed, but slightly less accepting when a wish to die had been expressed. In other words, whether or not the target has expressed a wish to die had a stronger influence on female than on male participants.

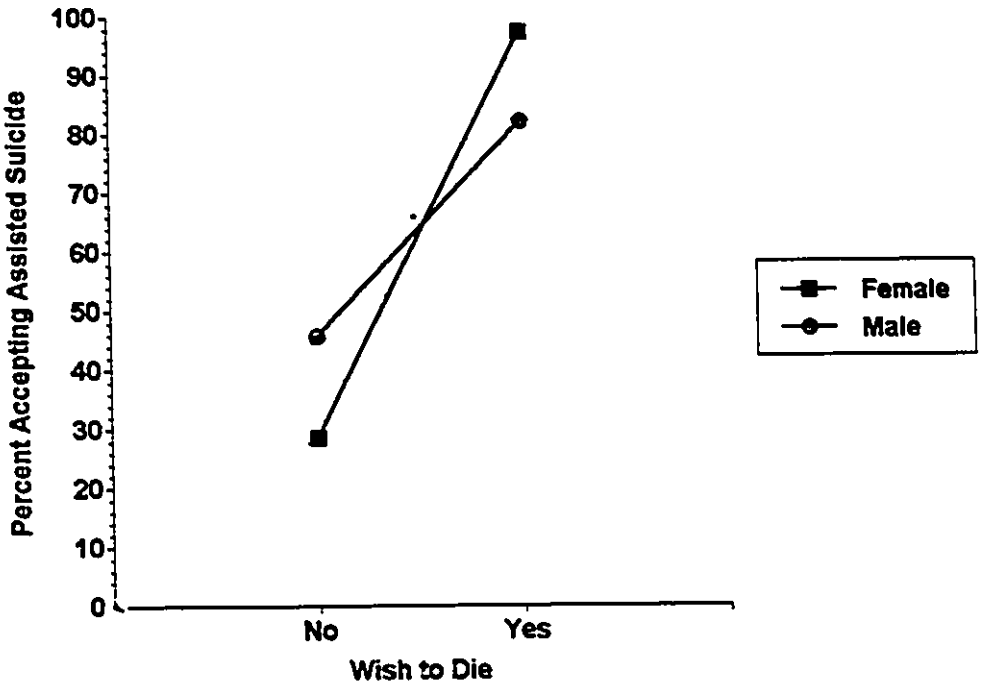

Figure 2. Percentage of participants accepting assisted suicide as a function of participant's gender and target's expressed wish to die.

The interaction between terminal illness and physical incapacitation revealed that the increase in acceptability based on the presence of a terminal illness was smaller when the target was physically incapacitated than when she was not (Figure 3). In other words, the nature of the illness (terminal or not terminal) made more of a difference in acceptability when the target was able to function physically.

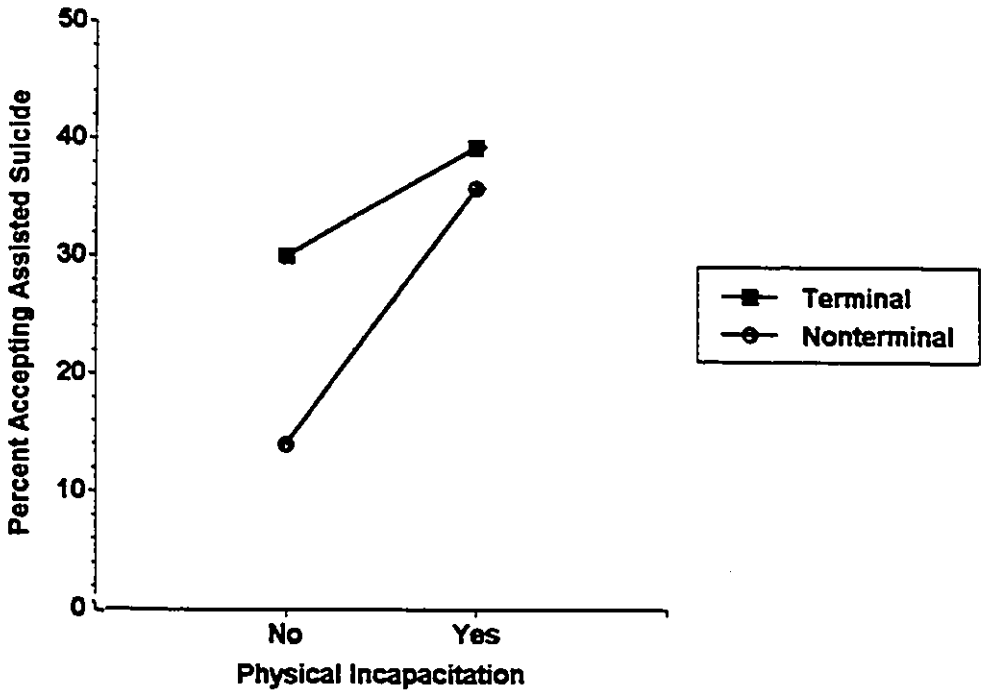

Figure 3. Percentage of participants accepting assisted suicide as a function of target's terminal illness and physical incapacitation.

The interaction between terminal illness and mental incapacitation indicated that the increase in acceptability on the basis of the presence of a terminal diagnosis was greater when the target was also mentally incapacitated (Figure 4).

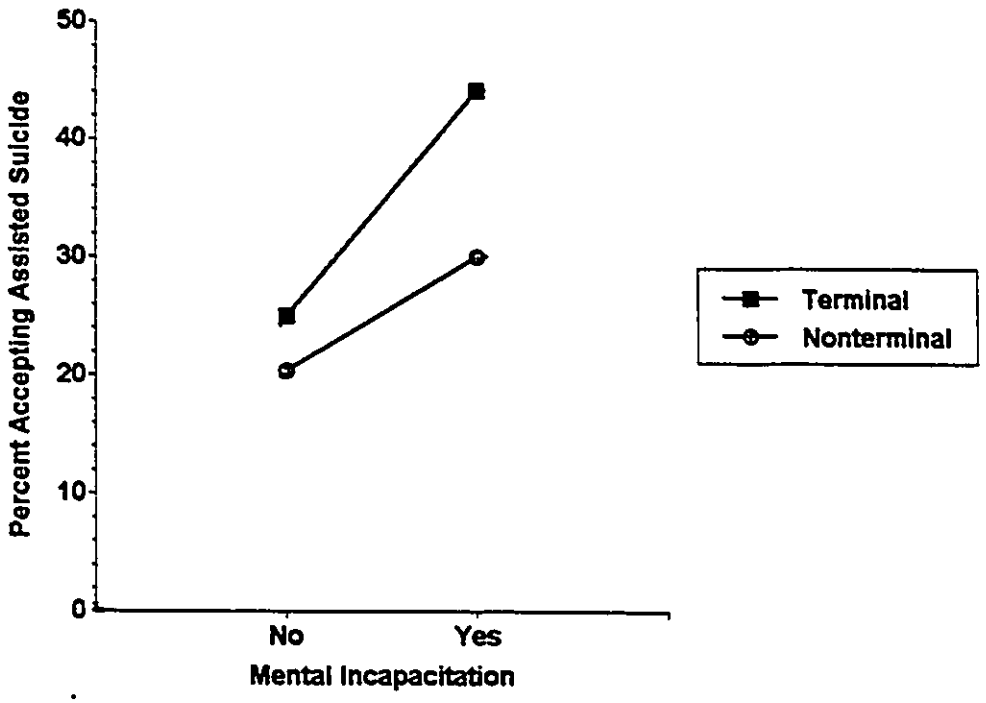

Figure 4. Percentage of participants accepting assisted suicide as a function of target's terminal illness and mental incapacitation.

With reference to the interaction between wish to die and physical incapacitation, the odds of a change in acceptability decreased on the basis of physical incapacitation when the individual had expressed a wish to die (Figure 5). In other words, the increase in acceptability based on the presence of physical incapacitation was smaller when the target had expressed a wish to die than when she had not expressed such a wish.

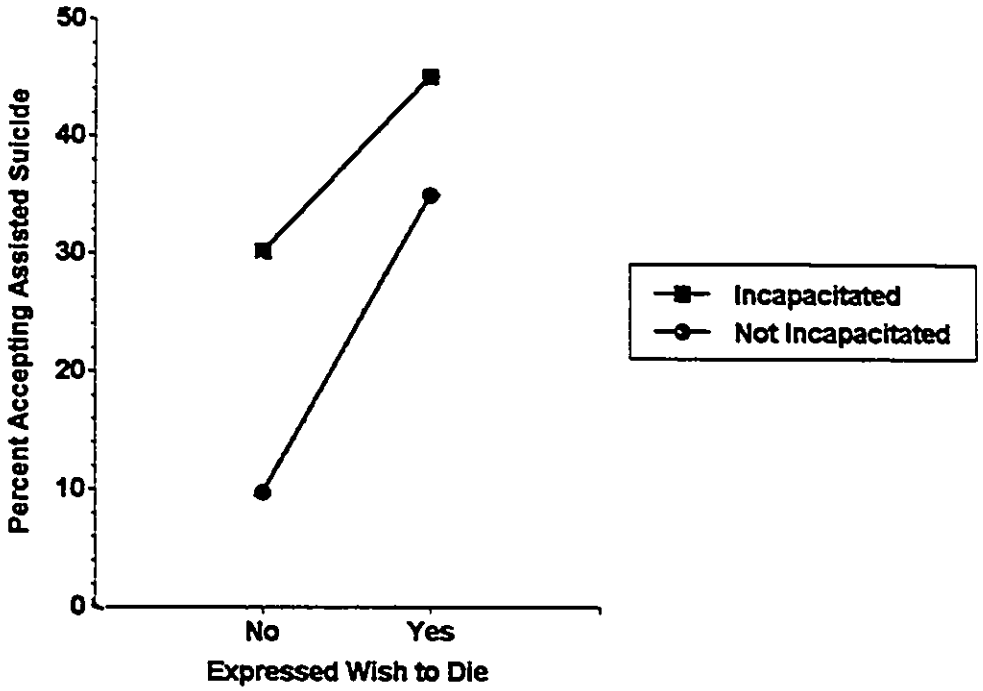

Figure 5. Percentage of participants accepting assisted suicide as a function of target's expressed wish to die and physical incapacitation.

The interaction between pain and mental incapacitation revealed that the odds of increasing acceptability for assisted suicide because the target was mentally incapacitated were greater when she was also in severe pain (Figure 6).

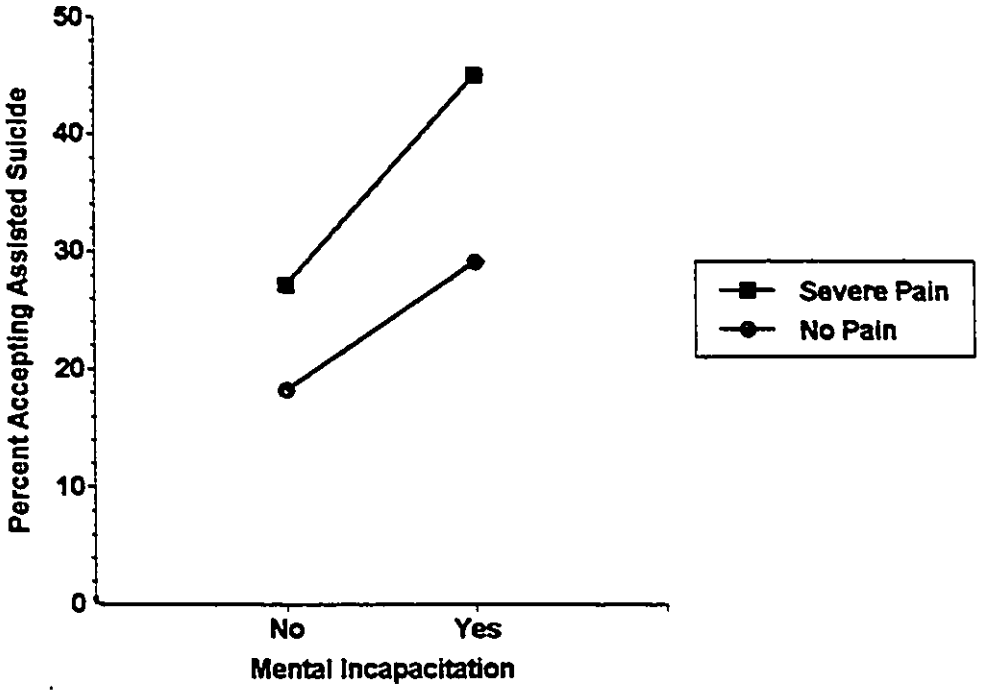

Figure 6. Percentage of participants accepting assisted suicide as a function of target's severity of pain and mental incapacitation.

The interaction between wish to die and mental incapacitation indicates that the odds of assisted suicide becoming an acceptable option because the person had expressed a wish to die were greater if she was also mentally incapacitated (Figure 7). In other words, mental functioning (incapacitated or not incapacitated) made more of a difference in acceptability when the target had expressed a wish to die than when she had not.

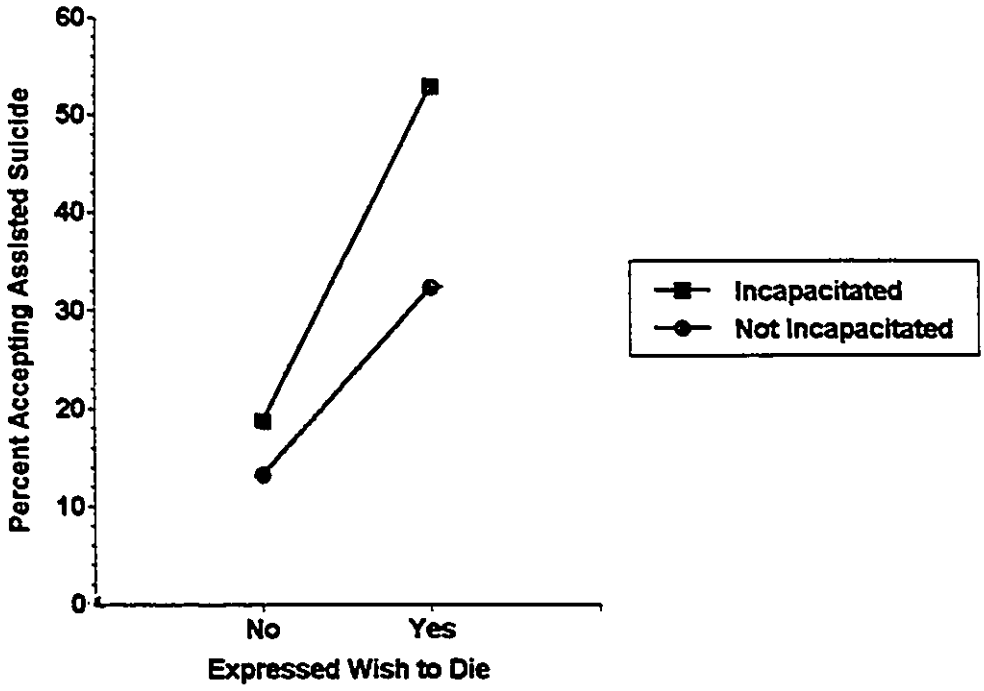

Figure 7. Percentage of participants accepting assisted suicide as a function of target's expressed wish to die and mental incapacitation.

Personal Determinants of Acceptability

In order to determine characteristics of the participants that best predicted the degree to which they found assisted suicide to be acceptable, correlational analyses were conducted to test for associations between the various measures. Overall acceptability for each participant was the sum of all ratings across the thirty-two vignettes administered to each participant.

Demographic Variables

As shown in Table 4, the more the participants defined themselves as religious, the less inclined they were to agree that a woman has a right to terminate her pregnancy and that assisted suicide should be legalized in Canada. Those who described themselves as very religious reported attending religious functions less often than those who described themselves as less religious. This negative relationship suggests that, for students, 'spirituality' and actual church attendance are not the same thing.

Other statistically significant correlations revealed the following associations: (1) the more religious people deemed themselves to be, the more accepting they were of assisted suicide, (2) people who regularly attended religious services tended to be pro-abortion and in favour of the legalization of assisted suicide, (3) the more acceptable participants viewed assisted suicide, the more they also viewed the legalization of assisted suicide, capital punishment and abortion as acceptable, and (4) participants who supported in the legalization of assisted suicide also tended to believe that capital punishment should be legalized.

Table 4

Means, Standard Deviations and Correlations for all Personal Characteristic Variables

Measure	M	SD	1	2	3	4	5	6	7	8	9	10
1. Age	21.21	5.34	---									
2. Gender	---	---	.09	---								
3. Church Attendance	2.30	1.88	.00	.08	---							
4. Religiosity	4.13	1.88	-.09	-.05	-.70'	---						
5. Politics	3.70	1.20	-.02	-.23	.09	-.07	---					
6. Read Information	---	---	.03	-.17	-.06	.03	-.10	---				
7. Acceptability of Assisted Suicide	.52	.50	.20	.08	-.27	.32'	-.08	.09	---			
8. Abortion	---	---	-.14	-.03	.43'	-.57'	.14	-.09	-.60'	---		
9. Legalization of Assisted Suicide	3.71	2.28	-.16	.02	.52'	-.56'	-.01	-.18	.53'	.68'	---	
10. Capital Punishment	---	---	-.17	.01	.20	-.28	-.09	.05	-.36'	.54'	.33'	---

Note: n=111.
* p<.001, two=tailed.

Measures

A correlational analysis of the relationship between the measures under investigation and acceptability of assisted suicide revealed several findings of interest (Table 5). Analyses between subscales rather than between total scales were performed for several reasons: (1) it was necessary to verify that a relationship existed between subscales, (2) it was believed that the Death Anxiety subscales relating particularly to one's own death would be better predictors than other subscales of this measure, although all subscales were included to determine whether this was in fact the case, and (3) the Religious Orientation Scale consists of three independent subscales that cannot be summed to yield a total score.

Table 5

Means, Standard Deviations and Correlations for all Scale Indicator Variables

Measure		M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.	Abortion	4.11	2.32	--													
2.	Capital Punishment	3.88	2.23	.29	--												
	Death Anxiety																
3.	Your Own Death	20.85	7.66	-.11	.06	--											
4.	Death of Others	24.29	8.19	-.00	-.01	.82***	--										
5.	Your Own Dying	25.60	9.19	-.11	.06	.77***	.83***	--									
6.	Dying of Others	25.41	9.25	-.04	.00	.72***	.69***	.80***	--								
	Religious Orientation																
7.	Extrinsic	53.02	11.08	.00	.16	-.01	-.01	-.06	-.01	--							
8.	Intrinsic	38.81	13.76	-.49***	-.25	.10	.04	.14	.13	.28	--						
9.	Quest	49.66	11.63	.20	-.13	-.05	-.01	-.05	.13	.40**	.06	--					
	Life Ownership Orientation																
10.	Life Belongs to God	22.84	7.34	-.56***	-.18	.22	.13	.26	.18	.24	.81***	.00	--				
11.	Life Belongs to Individual	15.63	5.29	.51***	.36*	-.22	-.11	-.24	-.10	.00	-.52***	.01	-.56***	--			
12.	Life Belongs to State	25.67	4.05	.20	.12	-.24	-.12	-.17	-.08	.15	-.24	-.03	-.17	.23	--		
13.	Acceptability of Assisted Suicide	.52	.50	.53***	.46***	.10	.13	.20	.07	-.11	.33*	-.10	-.39**	.41**	-.16	--	
14.	Gender	---	---	-.03	-.03	.10	.10	.09	.09	-.02	.02	.16	-.04	-.01	.09	.17	---

Note: n=111.
* p<.05, two-tailed.
** p<.01, two-tailed.
***p<.001, two-tailed.

The following associations were statistically significant:

(1) participants who believed that life belongs to the individual were more accepting of assisted suicide and its legalization and of the idea that a woman has a right to terminate her pregnancy, (2) participants who believed that life belongs to the individual were less likely to believe that life belongs to God and less likely to have an intrinsic orientation to religion, (3) participants who favoured legalized abortion tended to have lower scores on the intrinsic orientation to religion and were less likely to support the legalization of assisted suicide, (4) the more participants believed that life belongs to God, the less accepting they were of assisted suicide and abortion and the higher they scored on the intrinsic orientation to religion subscale, (5) individuals with higher quest orientation to religion scores tended to have higher scores on the exttrinsic orientation subscale, and (6) although the four death anxiety subscales were intercorrelated, no subscale of this measure was significantly correlated with any other measure.

Simultaneous regression was used to test the association between predictor variables and acceptability of assisted suicide. Only those predictors significantly correlated with acceptability were included. The results of the multiple regression analysis can be found in Table 6. The final model was highly significant, F (4, 104) = 12.56, $p<.0001$, and accounted for 35.3% of the overall variance.

Table 6

Summary of Multiple Regression for Measures Predicting Acceptability of Assisted Suicide

Measure	B	β	sr^2
1. Abortion	4.27	.27	4.2*
2. Life Belongs to the Individual	.91	.13	.9
3. Life Belongs to God	-1.44	-.28	2.3
4. Capital Punishment	4.13	.25	5.0*
5. Intrinsic Orientation to Religion	.34	.13	2.6

Note: n=111.
* $p<.001$.

Three separate repeated measures analyses of variance were performed to examine the association between the target's wish to die and the participants' extrinsic, intrinsic, and quest orientations to religion. According to Batson (1976), individuals can exhibit high levels of one or more orientations to religion. As a consequence, participants in the current study were categorized as scoring high or low on each orientation to religion. Median splits were conducted on scores for each religious orientation to categorize participants as either high or low.

Only the interaction between an intrinsic orientation to religion and a wish to die was significant ($F(1, 107) = 4.71$, $p<.05$). Participants with a low intrinsic religious orientation were more accepting than high intrinsic religious orientation participants of assisted suicide when a wish to die had been expressed. The two groups did not differ

as much in the absence of an expressed wish to die (Figure 8).

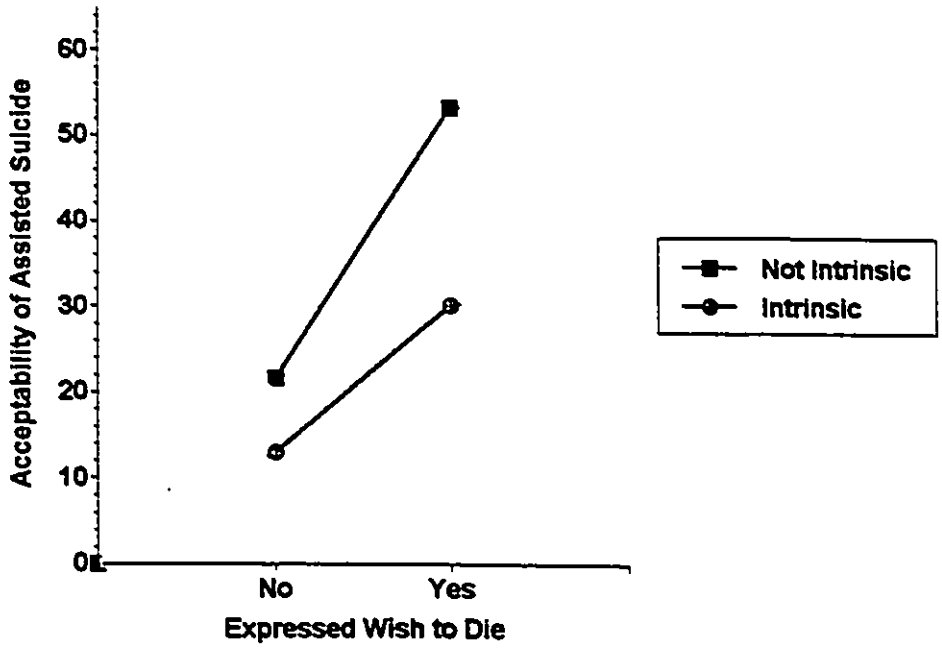

Figure 8. Percentage of participants accepting assisted suicide as a function of target's expressed wish to die and participant's intrinsic orientation to religion.

No other subscale or measure significantly predicted acceptability.

Analyses were also performed on two additional items. Fifty-five percent of the participants, when asked to respond to the statement, "Doctor-assisted suicide should be legalized in Canada," agreed with the statement, including 56.4% of the men and 54.2% of the women. Findings for the second item, "Who should decide whether a person should be allowed an assisted suicide?", are presented in Table 7. Respondents clearly chose the individual, the family, and the doctor as responsible for this decision;

the court, the government, and other (e.g., God) were less likely to be favoured to make these decisions.

Table 7

Who Should Decide Whether Assisted Suicide is Acceptable

Decision Made By	Number Agreeing	Percent Agreeing
Individual	95	85.59
Family	58	49.55
Doctor	55	43.24
Other (e.g. God)	11	9.91
Court	10	9.01
Government	2	1.80

Note: n=111.
Note: Percent agreeing does not sum to 100. Participants were given the opportunity to select more than one response.
Note: Participants who chose the Other category were asked to specify who was meant by Other; the majority of participants chose God.

These choices suggest that participants would be most comfortable with the decision of assisted suicide if that decision were made first by the individual, and second by either the family or the doctor. It appears that neither the court nor the government are viewed as appropriate arbiters.

CHAPTER 4

DISCUSSION

The purpose of the present study was to identify: (1) what conditions (i.e., terminal illness, physical incapacitation, mental incapacitation, pain, and an expressed wish to die) influence the acceptance of assisted suicide, and (2) the individual characteristics associated with the acceptance of assisted suicide.

Situational Determinants of Acceptability

The requirement of an expressed wish to die is central to the definition of assisted suicide; without the target's explicit request, his or her death would be defined as either euthanasia or homicide, depending on the merciful or malicious intent of the person causing death. Assisted suicide was consequently expected to be much more acceptable if an explicit wish to die had been expressed by the target than in the absence of such a wish. This hypothesis was supported; assisted suicide became substantially more acceptable when a wish to die was openly expressed than when it was not. This finding is consistent with Wade and Anglin's (1987) fingings.

It was hypothesized that acceptability of assisted suicide would increase when a wish to die was coupled with any one of a number of situational factors. This hypothesis was also partially supported. If a wish to die was coupled with mental incapacitation acceptability increased significantly over that displayed when each factor was presented alone. However, the coupling of a wish to die with other factors such as terminal illness and pain did not increase acceptability. One finding contradicted the hypothesis; the coupling of a wish to die with physical incapacitation served to decrease acceptability.

It was hypothesized that, in the absence of an expressed wish to die, the presence of one or more of the other factors would not increase acceptability significantly. Contrary to this expectation, each factor alone did significantly increase the acceptability of assisted suicide, regardless of whether or not a wish to die had been expressed. For example, assisted suicide was deemed substantially more acceptable for a person who was physically incapacitated than for a person who was not, whether or not the individual had expressed a wish to die. This finding would seem to support the argument of those who oppose any form of assisted suicide legislation on the basis of the 'slippery slope' concept. Although the intent of such a law might be to enable people to control their own lives (and deaths), it might also make it easier to justify involuntary euthanasia, that is, to relieve someone of their perceived misery.

Other explanations for this finding are also plausible, however. It will be recalled that the last sentence in the no expressed wish to die vignette was: "She has told you that she finds her condition unbearable, but has never asked you to help her to die." It is quite possible that at least some respondents inferred from this statement that the woman did in fact wish to die, even though she could not bring herself to use those exact words. It is also possible that the instruction given in the no expressed wish vignettes was sufficient to make participants put themselves affectively as well as cognitively in the place of a doctor caring for a woman who was in severe pain, unable to care for her own physical needs or no longer mentally competent. On the basis of the level of empathy thus elicited, participants may have inferred that while no verbal wish had been expressed, such a wish to die would likely be present in these circumstances. Further research could examine these inference and empathy hypotheses, including the association between cognition and affect and their relative roles in the endorsement of

assiisted suicide.

Other findings are also of interest. The combination of several of the situational determinants led to an increase in acceptability. Specifically, assisted suicide was judged especially acceptable for the woman who was both terminally ill and mentally incapacitated and for the woman who was both mentally incapacitated and in severe pain. The combination of terminal illness and physical incapacitation and wish to die and physical incapacitation led to significant decreases in acceptability relative to an additive combination of these variables. In these instances, a level of acceptability was reached that could not be surpassed, regardless of the addition of variables or situations. For example, acceptability levels were markedly different when physical functioning was assessed – those who were physically incapacitated were more often viewed as potential candidates for assisted suicide. When physical functioning was coupled with the level of pain experienced, however, physical functioning no longer mattered; the percentage of participants accepting assisted suicide for those who were in severe pain was not significantly different whether the individual was or was not able to function physically.

The finding that men were significantly more accepting of assisted suicide than women was consistent with previous research (Johnson et al., 1980; Jorgenson & Neubecker, 1981). When coupled with the target's expressed wish to die, however, women became more accepting of assisted suicide than men. This finding suggests that women are more sensitive to the wishes of the target. These findings together may signify a difference in the socialization of men and women in Canada, and could be explained as a function of willingness to act: men may be socialized to take action against undesirable situations whereas women are socialized to tolerate these same situations (Jorgenson & Neubecker, 1981). Further, women are socialized more often to

care for and nurture the sick, and may thus have felt less compelled than men to accept death as an alternative to the conditions presented. Women are also more often socialized to communicate verbally than men. As a consequence, the finding of increased acceptability for women when a wish to die was expressed is not surprising; women may rely more on communication from the target before taking action on their behalf, whereas men may instead take action on the basis of their own view of the situation.

Personal Determinants of Acceptability

It was hypothesized that acceptability of assisted suicide would be negatively correlated with death anxiety, one's life ownership orientation, and religious orientation. Specifically, it was expected that those with high levels of death anxiety, those who believed more that one's life belongs to God, and those who demonstrated either a greater means (extrinsic) or end (intrinsic) orientation to religion would not be accepting of assisted suicide. Conversely, it was expected that those with lower levels of death anxiety and those who were more convinced that life belongs either to the individual him/herself or to the state would be generally more accepting of assisted suicide. Finally, it was expected that individuals who demonstrated a greater quest orientation to religion would be conditionally accepting of assisted suicide. In other words, those with a higher quest orientation score would judge assisted suicide as acceptable only if a wish to die had been expressed; in the absence of such a wish, it was expected that these participants would be less likely to accept assisted suicide. Attitudes toward abortion and capital punishment were also included as variables in the analyses, although no predictions were made concerning their relative contributions.

The results failed to support any of these expectations. In fact, attitudes toward

abortion and capital punishment were the best predictors of the acceptability of assisted suicide. The correlation between acceptability and attitudes toward abortion was positive, meaning that those who were accepting of assisted suicide were also more likely to believe that a woman has a right to terminate her pregnancy, a finding supported by earlier research (Ho & Penney, 1991). It is possible that this finding reflects the commitment of some respondents to personal autonomy or self-determination, the belief that people have a right to control their own bodies and make life-and-death decisions for themselves.

The positive correlation found between acceptability of assisted suicide and capital punishment was somewhat surprising. Those who were accepting of assisted suicide were also more likely to believe that capital punishment should be legalized in Canada. This correlation may reflect a 'state control' mentality, a lack of respect for life and personal autonomy if these values interfere with the 'smooth running' of society.

The previous explanations assume that the sample included two different groups of people, those who supported assisted suicide and abortion but were opposed to capital punishment and those who supported assisted suicide and capital punishment but not abortion. A second possibility is that the same participants tended to endorse all three decisions due to the operation of personal autonomy (or self-determination) as a third variable. It could be argued that if personal autonomy or self-determination were the issue, capital punishment would be negatively correlated with assisted suicide. Capital punishment involves the justice system making the decision to end someone's life, a decision functionally opposite to the belief expressed by personal autonomy. This would be the case unless personal autonomy for participants reflected their belief of a right to autonomy for their own person rather than autonomy in its more global sense.

Participants may have been able to put themselves in the position of the woman requesting termination of a pregnancy or the woman requesting assisted suicide and, judging on that basis, decided that abortion and assisted suicide were valid and acceptable options. It may have been more difficult, however, for participants to put themselves in the place of an individual on death row, awaiting the termination of their own life, and they may instead have put themselves in the place of the inmate's victim or next potential victim, making the decision based on autonomy of the person in terms of their own safety, their own freedom to walk the streets. While this is one explanation of the findings, others may be equally valid. Further research is required to test all these possible explanations.

It had been predicted that those with a quest orientation would be more accepting of assisted suicide on the basis of an expressed wish to die. This was not the case. Instead, the only significant religious orientation/assisted suicide interaction was that high intrinsic orientation participants were less accepting than low intrinsic participants. Earlier research (e.g., Batson, 1976) suggested that those with an intrinsic orientation were those who followed religious doctrine unquestioningly. Organized religion generally does not condone assisted suicide. As a consequence, those individuals with an intrinsic orientation could also be expected to unquestioningly reject assisted suicide, because it is 'wrong' according to the church and these individuals do not question the teachings of the church.

One possible explanation for the failure to find the expected interaction between quest orientation and wish to die could again be participants' assumptions. Those with a quest orientation may have been reading vignettes involving no expressed wish with the assumption that a wish to die was nonetheless present. Further research is required to

test this possibility.

Policy Implications of the Current Research

Several of the findings of the present study have important implications for the current debates concerning assisted suicide. For instance, men were generally much more willing to accept assisted suicide than women, and women more often were in tune with the wishes of the target and accepted or rejected assisted suicide on that basis. This finding has strong implications for the creation of public policy and legislation. It may serve to bring this gender issue to light and raise questions among those with the power to legislate assisted suicide, the vast majority of whom are men. Ideally, this finding might also spur requests for more input by women into the debate.

Men's relative willingness to endorse assisted suicide regardless of an expressed wish to die, coupled with the finding that assisted suicide became significantly more acceptable in the presence of each situational factor een in the absence of an expressed wish to die suggests the need for stringent regulation of assisted suicide. These findings provide support for the idea that a voluntary, explicitly expressed wish to die should be made a necessary condition to the granting of an assisted suicide in proposed legislation.

Other findings also have implications for future legislation. Specifically, the current research asked participants whether or not assisted suicide should be legalized in Canada, and who should be made responsible for determining whether or not an assisted suicide should be granted. Speaking to the first issue, the legalization of assisted suicide was supported by the majority of participants. It is hoped that this finding will help to spur legislative activity on this issue. Speaking to the second issue, when asked who should be responsible, participants overwhelmingly agreed that it should be the individual, the family, and the doctor who decide whether or not assisted suicide is an

appropriate option. Participants also overwhelmingly agreed that such decisions should not be made either by the courts or by government. This also strongly suggests the need for assisted suicide legislation; it is safe to assume that participants do not want the decision made on a case-by-case basis in the courts, either before or after the fact. Rather, the present participants wanted the government to legislate assisted suicide (to legalize it) and to allow those closest to the situation to determine for themselves whether or not it is appropriate.

Directions for Future Research

Many research questions have been generated from the findings of the current study. One research possibility would be to test the role of empathy in decisions to accept or reject assisted suicide. Empathy may play a vital role in acceptability, such that participants able to empathize with the target may in fact infer a wish to die even though it has not been expressed.

The relationship between attitudes toward abortion, capital punishment, and acceptability also merits further study. It has been proposed that this relationship may be based on a need for autonomy, both for others and for oneself; however, this possibility has yet to be tested. Future research could explore whether or not participants are making decisions on the basis of self-determination, and, if so, who they are considering when making this decision.

Finally, many factors that may lead to changes in the acceptability of assisted suicide remain to be tested. For instance, factors such as disease label, age, and gender of the potential candidate for assisted suicide were not tested in the current study, because these factors would not be considered in formulating law. For example, it is doubtful that assisted suicide would be legalized for a person with AIDS but not for a

person with cancer, for only older people, or for only women. While less relevant to legislating assisted suicide, these factors are nonetheless of paramount importance to both assisted suicide and prejudice research, and should thus be considered in future endeavours.

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APPENDIX A

CONSENT FORM

Consent Form

The purpose of this study is to help us to understand how people view assisted suicide and related issues.

Your participation will take approximately 2 hours, and you will be awarded 2 bonus points for participating. You will be asked to read several paragraphs and respond to questions about them. You will also be asked to respond to a number of items about your attitudes toward some social issues, your personal views concerning religion and also concerning death and dying, and some very general questions about yourself.

It is very important that you answer questions as honestly and candidly as possible. The research being conducted today is **completely confidential.** Please be assured that you can not be identified from any of the information you provide. **Do not** write your name or any other identifying information on the survey booklet itself.

Participation in this study is **completely voluntary.** You may not be comfortable with some of the issues raised by this study. You have the right to withdraw at any time or to refuse to answer any questions without jeopardizing the bonus point allotted for completing this survey.
The data from this survey will be used in Gayle Vincent's M.A. thesis at the University of Windsor. Only Ms. Vincent and her advisors will see your answers. Summaries of the data and statistical tables will be included in the thesis and in any subsequent publications. A copy of the finished report will be made available upon completion in the Psychology Department.

This study has been cleared by the Psychology Department Ethics Committee. Ms. Vincent will be available during the study to address any questions or concerns you may have. If you have any questions or concerns either before or after participating in this survey, please contact any of the following people:

Gayle Vincent, Graduate Student	253-4232, ext. 2217
Dr. Shelagh Towson, Associate Professor	253-4232, ext. 2250
Dr. Stewart Page, Ethics Committee	253-4232, ext. 2243

Please take the top portion of this form with you. Thank you for your participation.

I, _____ (please print your full name), understand this information and voluntarily consent to participate in this study.

_____ _____

signature date

APPENDIX B

ATTITUDES TOWARD ASSISTED SUICIDE SURVEY

PART 1
ATTITUDES TOWARD ASSISTED SUICIDE

The following paragraphs describe women in different situations. Please read each paragraph carefully and take a moment to think about the woman and her situation. Then, give your opinion by circling the number that best represents your opinion. Note: these individual cases bear no resemblance to any person or situation known to the author.

Two years ago Brenda noticed that she was feeling tired all the time. One day she also noticed an unusual rash on her face. She went to the doctor and was diagnosed with lupus, a potentially fatal disease. Fortunately, Brenda's disease was caught early and her symptoms could be treated. Her prognosis is good; she has been told that she will live for many more years. Brenda has received medication to combat the fatigue and the rash. Although she still has lupus, she is still able work at a job that requires physical strength. Brenda is not in any pain as a result of this disease. Further, she is still fully capable mentally. Now, imagine that you are Brenda's doctor. She has told you that she finds her condition unbearable but has never asked you to help her to die.

How acceptable do you think it is for you to help Brenda to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Kim had been having terrible headaches. When they got so bad that they made her vomit, Kim went to the doctor. After several tests, the doctor told Kim that she had a brain tumor, a potentially fatal disease. Surgery and chemotherapy did not help, and the cancer has now spread to Kim's liver; she is not expected to live much longer. Kim has had to quit her job, a job that required physical stamina. She is now bed-ridden and has to be fed intravenously. She will probably be confined to a bed for the rest of her life. She also has to wear a diaper because she cannot control her bladder. Kim is in a great deal of pain. She receives injections of morphine every four hours to combat the pain, but even this is not effective. Further, the pain medication has caused Kim to lose touch with reality and she talks gibberish whenever she is awake. Now, imagine that you are Kim's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Kim to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Diane was rushed to the hospital last week because she suddenly felt so dizzy and weak that she fell down. After a series of tests Diane was diagnosed with multiple sclerosis, a potentially fatal disease. Diane's disease has progressed very quickly; it is not possible to slow its progression. Diane's doctor told her that she only has a few months to live. Diane had to quit working at a job that was physically demanding because her disease has made Diane very weak. Now she is confined to bed and must be fed by the nursing staff at the hospital. She will probably be confined to a bed or a wheelchair for the rest of her life. Medication has helped, and Diane is not in any pain as a result of the disease. Further, Diane is still mentally alert and capable of carrying on conversations with family and friends. Now, imagine that you are Diane's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Diane to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Janice was rushed to the hospital last week because she was having difficulty breathing and was coughing up blood. Janice was diagnosed with lung cancer, a potentially life-threatening disease. However, the cancer was caught in its early stages; surgery removed the cancer, and it has not recurred. Janice's doctor has told her that she will live for many more years. She has been able to continue working at a job that requires physical strength. She continues to take medication to stop any pain as a result of her disease and the treatments that followed it; as a consequence, she is not in any pain because of her disease. However, the medication is causing Janice to have problems with her memory; recently her boss noticed that Janice has forgotten the names of some of her coworkers and how to do some of her job-related duties. Now, imagine that you are Janice's doctor. She has told that she finds her condition unbearable, but has not asked you to help her to die.

How acceptable do you think it is for you to help Janice to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Angela had a cough she couldn't get rid of that she thought was simply a cold. She knew it was something more serious one day when she started coughing up blood. Angela went to the doctor. After several tests, the doctor told Angela that she had lung cancer, a potentially life-threatening disease. Surgery and chemotherapy did not help, and the cancer has now spread to Angela's stomach and kidneys; she is not expected to live much longer. She has had to quit a job that required physical stamina because she is now bed-ridden and has to be fed intravenously. She will probably be confined to bed for the rest of her life. She also has to wear a diaper because she cannot control her bladder. Angela is in a great deal of pain. She receives injections of morphine every four hours to combat the pain, but even this is not effective. The pain medication has also caused Angela to lose touch with reality and she talks gibberish whenever she is awake. Now, imagine that you are Angela's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Angela to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Louise had been feeling chest pain and shortness of breath for quite awhile. She went to the doctor because she thought she had pneumonia. After several tests, the doctor told Louise that she had lung cancer, a potentially fatal disease. The cancerous area is too large to remove surgically and chemotherapy hasn't helped. Louise's doctor has told her that she will not live more than six months. Louise had to quit her job, even though she is still physically capable of performing her duties at work. Louise is in incredible pain due to the tumor, and injections of morphine have not worked to control it; the pain is almost constant now. Also, the cancer has spread and has now invaded parts of her brain, areas that help her maintain her grasp on reality. Louise does not know where she is or who her family members are anymore; when her mother goes to visit her, Louise often acts as though she is a complete stranger, and her mother must introduce herself to Louise again at the beginning of every visit. Now, imagine that you are Louise's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Louise to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Anne went for her yearly physical exam a few months ago. During the exam, she mentioned to her doctor that she sometimes felt dizzy, that she sometimes had difficulty carrying the groceries from the car to the house because her arms were so weak, and that she felt constant pain in her arms and hands. Anne was diagnosed with multiple sclerosis, a potentially life-threatening disease. Anne's doctor has told her that her disease was caught early and could be treated. The prognosis is good; she is expected to live for many more years. Anne went back to work at a job that requires physical stamina. Anne is still very capable physically of carrying out her duties; however, medication has not stopped the pain caused by her disease. In addition, Anne appears to be having problems mentally; her boss has noticed that she now often has difficulty remembering how to perform job-related duties. Now, imagine that you are Anne's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Anne to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Last year, Jennifer noticed that she was feeling tired all the time. One day she also noticed an unusual rash on her face and a severe pain in her jaw. She went to the doctor and was diagnosed with lupus, a potentially life-threatening disease. Fortunately, Jennifer's disease was caught early and her symptoms could be treated; her doctor told her that she will live many more years. However, Jennifer had to quit working at a job that required physical stamina because, as a result of the disease and the medication she must take, Jennifer is no longer able to walk and is consequently confined to a wheelchair. She will probably be confined to a wheelchair for the rest of her life. She is also no longer able to eat on her own and must be fed intravenously. Jennifer gets injections of morphine to alleviate the pain caused by this disease, but this medication does not appear to work, as Jennifer is often found in her chair wincing in pain and crying. Further, as a result of the medication, Jennifer has also lost some ability to function mentally. She can no longer talk coherently and sometimes cannot understand what is said to her. When awake, Jennifer often talks gibberish. Now, imagine that you are Jennifer's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Jennifer to die?

Completely Acceptable — Completely Unacceptable

1 2 3 4 5 6 7

Pamela was diagnosed with lupus three years ago when she went to her doctor complaining of constant pain in her shoulders, wrists, hands and knees, pain which was particularly bad first thing in the morning. Pamela thought she had arthritis, and was surprised when she was diagnosed with lupus, a potentially life-threatening disease. Fortunately, Pamela's lupus was caught early; her doctor assured her that she will live for many more years. Pamela has continued to work at a job that is physically demanding. She was given medication to alleviate the symptoms of this disease, but the medication does not work and the pain persists. More recently, Pamela's pain has gotten even more severe and she has started complaining also of a constant headache. Pamela is still mentally alert and capable of carrying on conversations with her coworkers. Now, imagine that you are Pamela's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Pamela to die?

Completely Acceptable — Completely Unacceptable

1 2 3 4 5 6 7

Lucy went for her annual physical exam a few months ago. During the exam, she mentioned to her doctor that she sometimes felt lightheaded, that she sometimes had difficulty picking things up because she felt so weak, and that she often didn't know where her feet and legs were without looking. Lucy was diagnosed with multiple sclerosis, a potentially fatal disease. Her disease has progressed very quickly and although she has been given medication to alleviate her symptoms, her doctor has told her that she only has a few months to live. Lucy was able to go back to work at a job that is physically demanding. The medication has helped, and Lucy is not in any pain as a result of the disease. Lucy continues to be mentally alert. Now, imagine that you are Lucy's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Lucy to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Yvonne had been wheezing and feeling short of breath. When she also started coughing up blood, Yvonne went to the doctor. After several tests, the doctor told Yvonne that she had lung cancer, a potentially fatal disease. Surgery and chemotherapy did not help, and the cancer has now spread to Yvonne's liver; she is not expected to live much longer. She had to quit working at a job that required physical strength, because her disease has made her so weak that Yvonne is now confined to a wheelchair. She will probably be confined to a wheelchair for the rest of her life. She also has to wear a diaper because she cannot control her bladder and wets herself. Yvonne is not experiencing any pain as a result of this disease. Unfortunately, Yvonne appears to be suffering mentally; when her sister Joan went to visit her recently, Joan noticed that Yvonne could not remember certain words, such as cat and chair. Now, imagine that you are Yvonne's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Yvonne to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Carla's headaches have gotten progressively worse over the past few months. They are now so bad that they make her vomit. After a visit to her doctor, Carla learned that she has a brain tumor. Chemotherapy hasn't helped, and Carla's doctor has told her that she will not live more than a few months. Carla has continued to work at a job that is physically demanding. Medication helps, and she is not in any pain because of the tumor. However, lately her boss has noticed that Carla often stands in the office crying because she either cannot remember where her desk is or how to perform the duties her job requires. Now, imagine that you are Carla's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Carla to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Helen had frequent migraines. She went to her doctor recently to get medication to combat them. Her doctor suggested that routine tests be performed, tests which revealed that Helen had a brain tumor, a potentially fatal disease. Fortunately, the disease was caught early and, within the week, Helen had surgery to remove the tumor. The tumor has not recurred and Helen's prognosis is good; she is expected to live for many years. However, Helen has had to quit working at a job that was physically demanding. The surgery and the chemotherapy that followed have made Helen very weak physically. She is now bed-ridden and has to be fed intravenously. She will probably be confined to a wheelchair or to bed for the rest of her life. Helen takes medication which alleviates the pain resulting from this disease. Helen remains very alert mentally and is still capable of reading and visiting with friends. Now, imagine that you are Helen's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Helen to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Janet went for her annual physical exam a few months ago. During the exam, she mentioned to her doctor that she sometimes felt lightheaded, that she sometimes had difficulty picking up the tea kettle because she felt so weak, and that she often didn't know where her feet and legs were without looking. Janet was diagnosed with multiple sclerosis, a potentially fatal disease. Her disease had progressed very quickly and although she has been given medication to alleviate her symptoms, her doctor told her she only has a few months to live. Janet was able to go back work at a job that requires physical stamina. The medication has helped, and Janet is not in any pain as a result of the disease. Janet also continues to be mentally alert. Now, imagine that you are Janet's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Janet to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Karen thought she had the flu; she ached all over, had a fever, and was vomiting. After a week of being ill, one morning she noticed that she was also losing large patches of hair, a symptom not normally associated with the flu. Karen rushed to the clinic. After a series of tests Karen was diagnosed with lupus, a potentially fatal disease. Karen's disease fortunately has been caught early enough and can be treated; her prognosis is good. The doctor gave her medication and Karen was able to go back to work at a job that requires physical strength. The medication has helped alleviate her symptoms, and Karen is not in any pain as a result of the disease. Karen also remains mentally alert. Now, imagine that you are Karen's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Karen to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Darlene's headaches have gotten progressively worse over the past few months. After a visit to her doctor and many tests, Darlene learned that she has a brain tumor, a potentially life-threatening disease. Darlene's doctor told her that her disease has progressed quickly and that neither surgery nor chemotherapy will help; she cannot expect to live more than one year. Darlene continues to work at a job that is physically demanding. She was given medication to alleviate the symptoms of this disease, but the medication does not work and the extreme pain persists. More recently, Darlene's pain has gotten even more severe and she has started complaining that the headaches are causing nausea. Other than the pain, she is still mentally capable of performing her job-related duties. Now, imagine that you are Darlene's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Darlene to die?

Completely Acceptable — Completely Unacceptable

1 2 3 4 5 6 7

Heather was diagnosed with lupus three years ago when she went to her doctor complaining of constant pain in her abdomen, along with persistent nausea and vomiting that has lasted for weeks. Heather thought she had the flu, and was surprised when she was diagnosed with lupus, a potentially fatal disease. Her doctor told her that the disease had not progressed far and that it could be controlled with medication. She was assured that she would live many more years. Although Heather received medication, she continued to vomit and feel nauseated, which often caused her to feel dizzy as a result. Heather had to quit working at a job that was physically demanding, because the dizziness caused her to fall and she is now confined to a wheelchair. She will probably be confined to a wheelchair for the rest of her life. She also needs help bathing and dressing herself. Heather is not experiencing any pain because of this disease. However, she appears to be having problems mentally. Her old boss went to visit her recently and noticed that Heather talked gibberish during their entire visit and her boss could not understand what she was trying to say. Now, imagine that you are Heather's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Heather to die?

Completely Acceptable — Completely Unacceptable

1 2 3 4 5 6 7

Maggie went to the doctor because she could no longer control her headaches with over-the-counter medications. After a series of tests, Maggie's doctor told her that she has a brain tumor. Chemotherapy hasn't helped and the tumor is too big to remove. Maggie's doctor has told her that she will not live more than a few months. Maggie has been able to continue working at her physically demanding job. Medication has stopped any pain caused by the tumor. However, lately her coworkers have noticed that Maggie often stands in the office crying because she either cannot remember what she is doing at work or how to do it. Now, imagine that you are Maggie's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Maggie to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Lisa went to the hospital with what she thought was a migraine headache. After some tests, the doctor told her that her problem was more serious; Lisa had a brain tumor. Fortunately, the tumor was small and, although it was risky, was operable. Surgery was performed the next day and was successful; the tumor has not recurred and Lisa's doctor told her that she will live. However, while the surgery removed the tumor, it was also necessary to remove surrounding tissue, parts of the brain that controlled some aspects of physical functioning. Lisa had to quit her physically demanding job because, as a result of the surgery, she is no longer able to walk and thus is confined to a wheelchair; she is also no longer able to feed herself, and relies heavily on the nurses to help her eat. She will probably be confined to a wheelchair for the rest of her life. Lisa gets injections of morphine to alleviate her pain, but this medication appears not to work, as Lisa is often found in her chair wincing in pain and crying. Further, as a result of the surgery, Lisa can no longer talk coherently or understand what is said to her. When awake, Lisa often talks gibberish. Now, imagine that you are Lisa's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Lisa to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

During a routine physical examination, Gloria mentioned to her doctor that she had double vision and that she often felt very weak. Gloria was diagnosed with multiple sclerosis, a potentially fatal disease. Her doctor expected that with medical attention Gloria's disease would not get substantially worse; her prognosis is good, and her doctor expects that she will live for many more years. Gloria still feels weak occasionally, but has been able to continue working at a job that requires physical strength. Due to the medication she receives, Gloria is not in any pain as a result of her disease. However, Gloria appears to have problems functioning mentally. Recently Gloria's coworkers noticed that Gloria has often forgotten their names and sometimes cannot answer the simplest questions concerning her job. Now, imagine that you are Gloria's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Gloria to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Cheryl was rushed to the hospital last week because she was having difficulty breathing and was coughing up blood. Cheryl had also lost 15 kilograms in the past 2 months. After a series of tests Cheryl was diagnosed with lupus, a potentially fatal disease. Her doctor told her that the disease has progressed so far that it could not be controlled, and that she should not expect to live longer than a few months. Although she received medication, Cheryl continued to cough and feel weak. In fact, Cheryl is so weak that she can no longer feed herself; a volunteer has to come to her home to cook and feed her each meal. The medication that Cheryl takes alleviates any pain as a result of her disease. However, the regular volunteer has noticed that Cheryl has lost touch with reality, often talking gibberish when she attempts to feed her. Now, imagine that you are Cheryl's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Cheryl to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Roxanne thought she had pneumonia. When the symptoms kept getting worse and Roxanne started coughing up blood, she went to the doctor. Tests showed that Roxanne had lung cancer, a potentially fatal disease. Fortunately, the disease was caught early and Roxanne had surgery to remove the cancerous area. Cancer has not recurred and Roxanne is expected to live for years to come. However, Roxanne has had to quit working at a job that was very physically demanding. The surgery and the chemotherapy that followed have made Roxanne very weak. She is now bed-ridden and has to wear a diaper because she wets herself. She also has very little of her lungs left, and is never expected to regain the strength she once had; she will probably be confined to a wheelchair or to bed for the rest of her life. Roxanne takes medication which alleviates the pain resulting from this disease. Roxanne remains very alert mentally and is still capable of reading and doing crossword puzzles. Now, imagine that you are Roxanne's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Roxanne to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

After having a cough for several weeks, Debbie started to cough up blood. When that happened, she finally went to see her doctor. After a series of tests, she was told that she had lung cancer, a potentially fatal disease. Debbie's disease had not progressed very quickly; surgery was possible and was performed within the next week. After surgery, Debbie's prognosis was good; her doctor told her that she could expect to live a long life. However, her disease, the surgery, and the chemotherapy that followed it have made Debbie very weak. She had to quit her physically demanding job because she is now confined to bed and she now needs help to bathe and dress herself. She will probably be confined to a bed or a wheelchair for the rest of her life. Debbie continues to be in severe pain as a result of the disease, and medication does not seem to help. Even though she is now limited physically, Debbie is still mentally alert and is still capable of conversation with the nursing staff. Now, imagine that you are Debbie's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Debbie to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Allison had frequent migraines. She went to her doctor recently to get medication to combat them. Her doctor suggested that routine tests be performed. These tests revealed that Allison had a brain tumor, a potentially life-threatening disease. Her tumor was small enough to remove, and Allison had emergency surgery the next day. The tumor has not recurred and Allison's doctor has told her that her prognosis is good; she is expected to live a long life. Allison went back to work at a job that requires physical stamina. However, medication has not stopped the pain caused by her disease and the chemotherapy that followed it; she is often seen wincing in pain. Further, her coworkers have noticed that Allison is having trouble mentally; she has gotten lost several times in the building where she works, and has even been found crouched in a corner crying because she didn't know where she was. Now, imagine that you are Allison's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Allison to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Michelle went to her doctor complaining of constant pain in her abdomen, along with persistent nausea and vomiting that has lasted for weeks. Michelle thought she had either the flu or appendicitis and was surprised when she was diagnosed with lupus, a potentially life-threatening disease. Michelle's doctor told her that her disease had progressed quickly and she could not expect to live more than a few months. Michelle has continued to work at a very physically demanding job. She was given medication to alleviate the symptoms of this disease, but the medication does not work and the abdominal pain persists. More recently, Michelle's pain has gotten even more severe and she has started complaining also of a constant headache. The pain also makes it increasingly difficult for her to concentrate on her duties, although she is still mentally capable of doing her job. Now, imagine that you are Michelle's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Michelle to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Cathy was rushed to the hospital last week because she had a very high fever for three days and started having difficulty breathing. Cathy also complained of nausea and vomiting, and had lost 5 kilograms in the past 2 months. After a series of tests Cathy was diagnosed with lupus, a potentially fatal disease. Her doctor told her that the disease had not progressed far and that it could be controlled with medication. The doctor told her that she could expect to live many more years. Although Cathy received medication, she continued to have difficulty breathing, and also started experiencing a constant feeling of weakness. Cathy had to quit her working at a job that required physical strength; because of her weakness, she is now confined to a wheelchair. She will probably be confined to a wheelchair for the rest of her life. She also needs help to bathe and dress herself, and a volunteer comes in every morning to help her with these aspects of daily life. Cathy is not experiencing any pain because of this disease. Her old boss went to visit her recently and noticed that Cathy is having difficulty mentally; she had no idea who she was and often forgot that someone was even in the room with her. Now, imagine that you are Cathy's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Cathy to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Naomi hadn't been feeling quite right, so she went for a physical exam. During the exam, she told her doctor that she sometimes felt lightheaded and had double vision, and that she sometimes had trouble carrying things because the muscles in her arms felt so sore and weak. Naomi was diagnosed with multiple sclerosis, a potentially fatal disease. Naomi's disease had progressed very quickly; her doctor told her that she could not expect to live more than a few months. Her disease has made Naomi very weak; she has had to quit work at a job that was very physically demanding, and now is confined to bed. She will probably be confined to a bed or a wheelchair for the rest of her life. Further, because she can no longer control her bladder, she must wear a diaper. Medication has helped, and Naomi is not in any pain as a result of the disease. Naomi is still mentally alert, and is still capable of making conversation with her family and old coworkers. Now, imagine that you are Naomi's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Naomi to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Barb went to her doctor a few months ago, complaining of severe and chronic headaches. Tests revealed that Barb had a brain tumor, a potentially life-threatening disease. Fortunately, Barb's disease was caught early; her tumor was small enough to remove, and Barb had surgery the next day. The tumor has not recurred, and her doctor told her that she would live for a long time to come. Barb has continued to work at a job that is physically demanding. She was given medication to alleviate the pain caused by the disease and the treatment that followed, but the medication didn't not work and the constant pain remains; she often winces and cries because the pain is so bad. However, even although she is in pain, she is still mentally alert and capable of doing her job. Now, imagine that you are Barb's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Barb to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Susan had some difficulty swallowing recently, and had lost several kilograms as a result. She went to her doctor and, after a series of tests, learned that she had lung cancer, a potentially life-threatening disease. After her initial diagnosis, Susan's disease progressed very quickly; surgery was not possible and chemotherapy did not work to stop the growth of the cancer; it had spread to her stomach and bladder. Susan's doctor told her that she should not expect to live much longer. Susan had to quit working at a job that required physical strength because her disease, along with the chemotherapy, made her very weak; she could no longer stand on her own and is now confined to a wheelchair. She will probably be confined to a wheelchair for the rest of her life. More recently, Susan has had to start wearing a diaper because she can no longer control her bladder. Medication hasn't helped, and Susan constantly feels severe pain in her chest and abdomen because of this disease, pain that often causes her to cry. Susan is still mentally alert. Now, imagine that you are Susan's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Susan to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Sandra went for what she thought would be a routine physical exam. During the exam, she told her doctor that she occasionally felt dizzy and that she would feel either incredible pain or complete numbness in her feet and legs. Sandra was diagnosed with multiple sclerosis, a potentially life-threatening disease. Her doctor has told her that her disease has progressed quickly and that she will not live more than a few months. Sandra has continued to work at a job that requires physical stamina. Injections of morphine have not worked to control the incredible pain caused by this disease, and the pain is almost constant now. In addition, the disease seems to have affected Sandra's memory; she often talks gibberish that no-one can understand. Now, imagine that you are Sandra's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Sandra to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

Bonnie hadn't been feeling quite right, so she went for a physical exam. During the exam, she told to her doctor that she sometimes felt lightheaded and had double vision, and that she sometimes had trouble carrying her briefcase because she felt so weak. Bonnie was diagnosed with multiple sclerosis, a potentially fatal disease. Her doctor told her that the disease had progressed fast and that she could not expect to live much longer. Although Bonnie received medication that stopped the double vision, the feeling of weakness and the lightheadedness could not be controlled. Bonnie had to quit her physically demanding job because dizziness caused her to fall; she is now confined to a wheelchair. She will probably be confined to a wheelchair for the rest of her life. She also needs help to bathe and dress herself, and a volunteer comes in every morning to help her with these aspects of daily life. Medication has helped, and Bonnie is not experiencing any pain because of this disease. Bonnie remains mentally alert and is capable of having conversations with the volunteers. Now, imagine that you are Bonnie's doctor. She has told you that she finds her condition unbearable, and has asked you to help her to die.

How acceptable do you think it is for you to help Bonnie to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

After having had some difficulty swallowing recently, and losing several kilograms as a result, Teresa finally went to see her doctor. After a series of tests, she was told that she had lung cancer, a potentially fatal disease. Teresa's disease had not progressed very quickly; surgery was possible, and was performed within the next week. After surgery, Teresa's prognosis was good; her doctor told her that she could expect to live many more years. Teresa had to quit working at a job that was physically demanding because her disease, the surgery, and the chemotherapy that followed it has made Teresa very weak, and now she is confined to bed. Further, because she can no longer control her bladder, she must wear a diaper. Unfortunately, Teresa continues to be in severe pain as a result of the disease, and medication does not seem to help. She is still mentally alert, and is still capable of carrying on conversations with the nursing staff. Now, imagine that you are Teresa's doctor. She has told you that she finds her condition unbearable, but has never asked you to help her to die.

How acceptable do you think it is for you to help Teresa to die?

Completely Acceptable						Completely Unacceptable
1	2	3	4	5	6	7

You have completed Part 1. Please proceed to Part 2.

APPENDIX C

DEMOGRAPHIC INFORMATION

PART 2
DEMOGRAPHIC INFORMATION

1. Gender Male _____ Female _____

2. Age _____

3. Marital Status

Single	_____
Married	_____
Common-Law	_____
Separated	_____
Divorced	_____
Widowed	_____

4. Ethnic Background _____

5. Religion _____

6. How often do you attend religious functions?

several times a week	_____
once a week	_____
several times a month	_____
once a month	_____
several times a year	_____
once a year	_____
never	_____

7. How religious are you? Please circle the answer that most reflects how religious you feel you are.

Very Religious			Somewhat Religious			Not At All Religious
1	2	3	4	5	6	7

8. How would you describe your political viewpoint? Circle the number that most reflects how liberal or conservative you feel your political outlook is.

Very liberal						Very conservative
1	2	3	4	5	6	7

APPENDIX D

ATTITUDES TOWARD RELATED ISSUES

ATTITUDES TOWARD RELATED ISSUES

How disturbed or made anxious are you by the following aspects of death and dying? Read each item and answer it quickly. Don't spend too much time thinking about your response. We want your first impression of how you think right now. Circle the number that best represents your feeling.

		Not At All Anxious				Very Anxious
Your Own Death						
1.	the total isolation of death	1	2	3	4	5
2.	the shortness of life	1	2	3	4	5
3.	missing out on so much after you die	1	2	3	4	5
4.	dying young	1	2	3	4	5
5.	how it will feel to be dead	1	2	3	4	5
6.	never thinking or experiencing anything again	1	2	3	4	5
7.	the possibility of pain and punishment during life-after death	1	2	3	4	5
8.	the disintegration of your body after you die	1	2	3	4	5
Your Own Dying						
9.	the physical disintegration involved in a slow death	1	2	3	4	5
10.	the pain involved in dying	1	2	3	4	5
11.	the intellectual degeneration of old age	1	2	3	4	5
12.	that your abilities will be limited as you lay dying	1	2	3	4	5
13.	the uncertainty as to how bravely you will face the process of dying	1	2	3	4	5

		Not At All Anxious				Very Anxious
14.	your lack of control over the process of dying	1	2	3	4	5
15.	the possibility of dying in a hospital away from friends and family	1	2	3	4	5
16.	the grief of others as you lay dying	1	2	3	4	5
The Death of Others						
17.	the loss of someone close to you	1	2	3	4	5
18.	having to see their dead body	1	2	3	4	5
19.	never being able to communicate with them again	1	2	3	4	5
20.	regret over not being nicer to them when they were alive	1	2	3	4	5
21.	growing old alone without them	1	2	3	4	5
22.	feeling guilty that you are relieved that they are dead	1	2	3	4	5
23.	feeling lonely without them	1	2	3	4	5
24.	envious that they are dead	1	2	3	4	5
The Dying of Others						
25.	having to be with someone who is dying	1	2	3	4	5
26.	having them want to talk about death with you	1	2	3	4	5
27.	watching them suffer from pain	1	2	3	4	5
28.	having to be the one to tell them that they are dying	1	2	3	4	5
29.	seeing the physical degeneration of their body	1	2	3	4	5

		Not At All Anxious				Very Anxious
30.	not knowing what to do about your grief at losing them when you are with them	1	2	3	4	5
31.	watching the deterioration of their mental abilities	1	2	3	4	5
32.	being reminded that you are going to go through the experience also one day	1	2	3	4	5

You are halfway through! Stretch, relax, and go on when ready.

PART 3

Please circle the number that most reflects your agreement with each statement. Circling the number "1" signifies that you **strongly agree** with the statement; circling the number "7" means that you **strongly disagree** with it.

33. Although I believe in my religion, I feel that there are many more important things in my life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

34. It is important for me to spend periods of time in private religious thought and meditation.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

35. I was not very interested in religion until I began to ask questions about the meaning and purpose of my life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

36. It doesn't matter so much what I believe so long as I lead a moral life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

37. If not prevented by unavoidable circumstances, I attend church.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

38. I have been driven to ask religious questions out of a growing awareness of the tensions in my world and in my relation to my world.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

39. The primary purpose of prayer is to gain relief and protection.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

40. I try hard to carry my religion over into all my other dealings in life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

41. My life experiences have led me to rethink my religious convictions.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

42. The church is most important as a place to formulate good social relationships.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

43. The prayers I say when I am alone carry as much meaning and personal emotion as those said by me during services.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

44. God wasn't very important for me until I began to ask questions about the meaning of my own life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

45. What religion offers me most is comfort when sorrows and misfortune strike.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

46. Quite often I have been keenly aware of the presence of God or the Divine Being.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

47. It might be said that I value my religious doubts and uncertainties.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

48. I pray chiefly because I have been taught to pray.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

49. I read literature about my faith (or church).

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

50. For me, doubting is an important part of what it means to be religious.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

51. Although I am a religious person I refuse to let religious considerations influence my everyday affairs.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

52. If I were to join a church group I would prefer to join a Bible study group rather than a social fellowship.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

53. I find religious doubts upsetting.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

54. A primary reason for my interest in religion is that my church is a congenial social activity.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

55. My religious beliefs are what really lie behind my whole approach to life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

56. Questions are far more central to my religious experience than are answers.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

57. Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economic well-being.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

58. Religion is especially important to me because it answers many questions about the meaning of life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

59. As I grow and change, I expect my religion also to grow and change.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

60. One reason for my being a church member is that such membership helps to establish a person in the community.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

61. I am constantly questioning my religious beliefs.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

62. I do not expect my religious convictions to change in the next few years.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

63. The purpose of prayer is to secure a happy and peaceful life.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

64. There are many religious issues on which my views are still changing.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

You are almost finished! The last part is ahead.

PART 4

Please circle the number that most reflects your agreement with each of the following statements. Circling the number "1" signifies that you **strongly agree** with the statement; circling the number "5" means that you **strongly disagree** with the statement.

65. If I lost everything I own in a fire, I would rely on God to put my life back together.

Strongly Agree				Strongly Disagree
1	2	3	4	5

66. The only way society can get better is if the government creates more social programs.

Strongly Agree				Strongly Disagree
1	2	3	4	5

67. I believe God controls what happens to me.

Strongly Agree				Strongly Disagree
1	2	3	4	5

68. I feel disappointed when I can't count on God.

Strongly Agree				Strongly Disagree
1	2	3	4	5

69. If I lost everything in a fire, I would rely on the government to put my life back together.

Strongly Agree				Strongly Disagree
1	2	3	4	5

70. Only God is responsible for what goes on.

Strongly Agree				Strongly Disagree
1	2	3	4	5

71. I believe an individual has the right to decide whether to live or die.

Strongly Agree				Strongly Disagree
1	2	3	4	5

72. Only the government is responsible for what really goes on.

Strongly Agree				Strongly Disagree
1	2	3	4	5

73. I feel secure when I live in a society that takes care of me.

Strongly Agree				Strongly Disagree
1	2	3	4	5

74. If I lost everything I own in a fire, I would rely on myself to put my life back together.

Strongly Agree				Strongly Disagree
1	2	3	4	5

75. The only way society can get better is if we all communicate more with God.

Strongly Agree				Strongly Disagree
1	2	3	4	5

76. I feel secure when I rely on myself.

Strongly Agree				Strongly Disagree
1	2	3	4	5

77. I believe the government controls what happens to me.

Strongly Agree				Strongly Disagree
1	2	3	4	5

78. The only way society can get better is if we each take care of our own problems ourselves.

Strongly Agree				Strongly Disagree
1	2	3	4	5

79. I feel disappointed when I can't count on myself.

Strongly Agree				Strongly Disagree
1	2	3	4	5

80. Only God has the right to decide whether an individual should live or die.

Strongly Agree				Strongly Disagree
1	2	3	4	5

81. I believe I control what happens to me.

Strongly Agree				Strongly Disagree
1	2	3	4	5

82. Only I am responsible for what really goes on.

Strongly Agree				Strongly Disagree
1	2	3	4	5

83. I feel disappointed when I can't count on the government.

Strongly Agree				Strongly Disagree
1	2	3	4	5

84. I believe the government has the right to decide whether a person lives or dies.

Strongly Agree				Strongly Disagree
1	2	3	4	5

85. I feel secure when I communicate with God.

Strongly Agree				Strongly Disagree
1	2	3	4	5

Please read the following statement and circle the number that most closely reflects your agreement. The number "1" means that you **strongly agree** with the statement; the number "7" means that you strongly disagree with it.

86. It is acceptable for a woman to terminate her pregnancy by having an abortion.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

87. Capital punishment should be legalized in Canada.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

88. Doctor-assisted suicide should be legalized in Canada.

Strongly Agree						Strongly Disagree
1	2	3	4	5	6	7

89. Who should decide whether a person should be allowed an assisted suicide? Please check as many as you feel apply.

the individual him/herself _____
the individual's doctor _____
the individual's family _____
the government _____
the court (legal system) _____
other _____
Please specify _____

90. Have you read about or thought about the subject of assisted suicide before?

_____

_____

_____

91. I would appreciate any comments you have concerning the issue of assisted suicide or concerning any of the questions on the survey. Use the back of this page if necessary.

_____

_____

_____

APPENDIX E

DEBRIEFING LETTER AND RESOURCES FOR PSYCHOLOGICAL HELP

Dear Participant:

I would like to thank you very much for participating in this research project. The information you have given me will help me, my research supervisor, and the academic community as a whole to better understand what affects our attitudes toward assisted suicide. I want to stress that there were no right or wrong answers to any of the questions I asked you and that your responses will be kept completely anonymous.

You may wonder why you had to read and respond to so many paragraphs about women in different situations. Assisted suicide is a very controversial issue and whether or not it should be acceptable is still being debated in courts across Canada and within government. There are so many factors related to the issue of assisted suicide and it is still unclear under what conditions, if any, it becomes viewed as an acceptable option for Canadians. By asking you to read these paragraphs and give your opinion concerning the acceptability in each of these situation, I was testing whether or not assisted suicide is deemed acceptable if the person: has or doesn't have a terminal illness; is or is not in severe pain; can or can not function physically; can or can not function mentally; and has or has not expressed a wish to die.

I also asked you to fill out several different measures at the end of the survey. These measures will be used to see if people who are generally in favour of assisted suicide have different characteristics than people who are generally not in favour of it. The questions measured your level of death anxiety, your religious orientation, and who you feel is in charge of your life. Again, I must stress that there were no right or wrong answers to any of these questions, and that the information you gave me today is anonymous; there is no way your response to any question can be traced back to you.

I hope this survey has not upset you in any way. Reading about people in these situations may be very stressful and may raise issues for you in your own life. If you would like to speak to me concerning this survey, please feel free to stay afterwards to talk to me about it, or call me at 253-4232 (2217). My supervisor, Dr. Shelagh Towson, is also available, at 253-4232 (2250), and Dr. Stewart Page, chairman of the Ethics Committee, is available at 253-4232 (2243). I have also attached the names and phone numbers of other resources that are available to you if you have any concerns or feelings raised either as a result of the survey or from other issues in your own personal life.

Sincerely,

Gayle Vincent

RESOURCES FOR PSYCHOLOGICAL HELP

For anyone who has any concerns or feelings raised either as a result of this survey or from any other issues in your own personal life, the following are a list of available resources to help you. Please keep this list for your own information.

Office of Student Services (For students in residence)	253 - 3410 Room 50, Vanier Hall
Peer Support Centre (For all students)	971 - 3633 1st Floor, Cody Hall
Psychological Services (For all students)	973 - 7012 Sunset Avenue
Windsor Distress Centre (All crises)	256 - 5000

VITA AUCTORIS

Gayle Vincent was born in Banff, Alberta, on June 9, 1964. She received her highschool diploma from Lindsay Thurber Comprehensive High School in Red Deer, Alberta (June 1982). After several years of self-exploration, she entered the University of Lethbridge, where she completed her Bachelor of Arts degree in Psychology, With Distinction (April 1993). Since September 1993 she has been enrolled in the Doctoral programme in Applied Social Psychology at the University of Windsor.